Attachment 4.19-C
STATE IDAHO

1. Payments may be made for reserving beds in long term facilities for recipients during their temporary absence if the facility charges private paying patients for reserve bed days, subject to the following limitations:

a. Facility Occupancy Limits. Payment for periods of temporary absence from long term care facilities will not be made when the number of unoccupied beds in the facility on the day preceding the period of temporary absence in question is equal to or greater than the larger of:

i. Five (5) beds; or

ii. Five percent (5%) of the total number of licensed beds in the facility.

b. Time Limits. Payments for periods of temporary absence from long term care facilities will be made for:

i. home visits for other than ICF/MR residents of up to three (3) days per visit and not to exceed a total of fifteen (15) days in any consecutive twelve (12) month period so long as the days are part of a treatment plan ordered by the attending physician.

ii. Therapeutic home visits for ICF/MR residents of up to thirty-six (36) days in any consecutive twelve (12) month period so long as the days are part of a written treatment plan ordered by the attending physician. Prior approval from the Regional Medicaid Unit must be obtained for any home visits exceeding fourteen (14) consecutive days.

c. Limits on Amount of Payments. Payment for reserve bed days will be the lesser of the following:

i. Seventy-five percent (75%) of the audited allowable costs of the facility unless the facility serves only ICF/MR residents, in which case the payment will be one hundred percent (100%) of the audited allowable costs of the facility; or

ii. The rate charged to private paying patients for reserve bed days.

IDAPA 16
TITLE 03
Chapter 10

16.03.10 - RULES GOVERNING MEDICAID PROVIDER REIMBURSEMENT IN IDAHO

000. LEGAL AUTHORITY.
Title XIX (Medicaid) of the Social Security Act, as amended, is the basic authority for administration of the federal program (see 42 CFR Part 447). Title 56, Chapter 1, Idaho Code, establishes standards for provider payment. Section 56-202, Idaho Code, provides that the Department is responsible for administering the program. Further it authorizes the Department to take necessary steps for its proper and efficient administration. (7-1-99)T

01. General. (7-1-93)

a. Fiscal administration of the Idaho Title XIX Medicaid Program will be in accordance with these rules and the Federal (42 CFR Part 447 Provider Reimbursement Manual (PRM) Part I and Part II, HCFA Publication 15-1 and 15-2, which is hereby incorporated by reference. These materials are available from HCFA, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the internet @ http://www.access.gpo.gov/nara/cfr/cfr-table-search.html). The provisions shall apply unless otherwise authorized. (7-1-99)T

b. Generally accepted accounting principles, concepts and definitions shall be followed in determining acceptable accounting treatments except as otherwise provided. (1-16-80)

02. Compliance As Condition Of Participation. Compliance with the provisions in this chapter, its amendments, and additions is required for participation in the Idaho Title XIX (Medicaid) Program. (7-1-99)T

001. TITLE.
The rules in this chapter are to be cited in full as Idaho Department of Health and Welfare Rules, IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho". (12-31-91)

002. REIMBURSEMENT PROVISIONS FOR STATE OWNED OR OPERATED ICF/MR FACILITIES.
Provisions of these rules do not apply to ICF/MR facilities owned or operated by the state of Idaho. Reimbursement of such facilities will be governed by the principles set forth in the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars ($5,000). (7-1-99)T

003. ADMINISTRATIVE APPEALS.
Hearings will be conducted in conformance with IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings And Declaratory Rulings". (7-1-99)T

004. DEFINITIONS.

01. Accrual Basis. An accounting system based on the matching principle. Revenues are recorded when they are earned; expenses are recorded in the period incurred. (1-16-80)

02. Allowable Cost. Costs which are reimbursable, and sufficiently documented to meet the requirements of audit. (1-16-80)

03. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (1-16-80)

04. Appraisal. The method of determining the value of property as determined by a MAI appraisal. The appraisal must specifically identify the values of land, buildings, equipment and goodwill. (9-15-84)

05. Assets. Economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles. (1-1-82)

06. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (1-16-80)

07. Bed-Weighted Median. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (7-1-99)T

08. Beneficiaries. Persons who are eligible for and receive benefits under federal health insurance programs such as Title XVIII and Title XIX. (1-16-80)

09. Betterments. Improvements to assets which increase their utility or alter their use. (1-16

10. Capitalize. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (1-16-80)

11. Case Mix Component. The portion of the facility's rate, direct care component, that is determined from quarterly case mix indices. The case mix component of a facility's rate is established at the beginning of each calendar quarter, based on the case mix indices calculated on the picture date of the preceding quarter. (7-1-99)T

12. Case Mix Index. A numeric score assigned to each facility resident, based on the resident's physical and mental condition, which projects the amount of relative resources needed to provide care to the resident. (7-1-99)T

a. Facility Wide Case Mix Index. The average of the entire facility's case mix indices identified at each picture date during the cost reporting period. If case mix indices are not available for applicable quarters due to lack of data, case mix indices from available quarters will be used. (7-1-99)T

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG's classification. Medicaid or non-Medicaid status will be based upon information contained in claims and MDS databases. To the extent that Medicaid identifiers are found to be incorrect at the time of the audit, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (7-1-99)T

c. State-Wide Average Case Mix Index. The simple average of all facilities "facility wide" case mix indices used in establishing the reimbursement limitation July 1 of each year. The state-wide case mix index will be calculated annually during each July 1 rate setting. (7-1-99)T

13. Common Ownership. An individual, individuals, or other entities which have equity, or evidence ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (7-1-99)T

14. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (1-16-80)

15. Control. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (7-1-99)T

16. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or material which are related or so considered for cost-accounting purposes. (1-16-80)

17. Cost Component. The portion of the facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a facility's rate is established annually at July 1 of each year.(7-1-99)T

18. Cost Reimbursement System. A method of fiscal administration of Title XIX which compensates the provider on the basis of expenses incurred. (1-16-80)

19. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (7-1-99)T

20. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (1-16-80)

21. Costs Related To Patient Care. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. (7-1-99)T

22. Costs Not Related To Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are not allowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (7-1-99)T

23. Customary Charges. Customary charges are the regular rates for various services which are recorded for patients liable for such charges. Those charges are to be adjusted downward, where the provider does not impose such charges on most patients liable for payment on a charge basis or, fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt (see Chapter 3, Sections 310 and 312, PRM). (7-1-99)T

24. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the provider. However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (7-1-97)

25. Department. The Department of Health and Welfare of the state of Idaho. (1-16-80)

26. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (1-1-82)

27. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (7-1-99)T

a. Direct nursing salaries which include the salaries of registered nurses, licensed professional nurses, certified nurse's aides, and unit clerks; and (7-1-99)T

b. Routine nursing supplies; and (7-1-99)T

c. Nursing administration; and (7-1-99)T

d. Direct portion of Medicaid related ancillary services; and (7-1-99)T

e. Social services; and (7-1-99)T

f. Raw food; and (7-1-99)T

g. Employee benefits associated with the direct salaries. (7-1-99)T

28. Director. The Director of the Department of Health and Welfare or his designee. (1-1-

29. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (9-15-84)

30. Facility. An entity which contracts with the Director to provide services to recipients in a structure owned, controlled, or otherwise operated by such an entity, and which entity is responsible for operational decisions in conjunction with the use of the term "facility": (1-1-82)

a. The term "Nursing Facility" or "NF" is used to describe all non-ICF/MR facilities certified to provide care to Medicaid and Medicare patients; (2-1-91)

b. "Free-standing Nursing Facility" means a nursing facility, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in Section 39-1301(a), Idaho Code; or (9-28-90)

c. "Hospital-based Nursing facility" means a nursing facility, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which is owned, managed, or operated by, or is otherwise a part of a hospital, as defined in Section 39-1301(a), Idaho Code. (7-1-99)T

d. "Rural Hospital-Based Nursing Facilities." Those hospital-based nursing facilities not located within metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (7-1-99)T

e. "Urban Hospital-Based Nursing Facilities." Those hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (7-1-99)T

31. Fiscal Year. The business year of an organization. (1-16-80)

32. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (11-4-85)

33. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (1-16-80)

34. GAAP. Generally accepted accounting principles, pronounced "gap". (1-16-80)

35. Generally Accepted Accounting Principles. Those concepts, postulates, axioms, etc., which are considered standards for accounting measurement. (1-16-80)

36. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is nonallowable, nonreimbursable expense. (9-15-84)

37. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (1-1-82)

38. ICF/MR. An intermediate care facility for the mentally retarded. (9-15-84)

39. ICF/MR Living Unit. The specific property or portion thereof that an ICF/MR uses to house patients. (7-1-97)

40. Improvements. Improvements to assets which increase their utility or alter their use. (1-16-80)

41. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (7-1-99)T

a. Administrative and general care costs: and (7-1-99)T

b. Activities; and (7-1-99)T

c. Central service and supplies; and (7-1-99)T

d. Laundry and linen; and (7-1-99)T

e. Dietary (non-"raw food" costs); and (7-1-99)T

f. Plant operations and maintenance (excluding utilities); and (7-1-99)T

g. Medical records; and (7-1-99)T

h. Employee benefits associated with the indirect salaries; and (7-1-99)T

i. Housekeeping; and (7-1-99)T

j. Other costs not included in direct care costs or costs exempt from cost limits. (7-1-99)T

42. Inflation Adjustment. Cost used in establishing a facility's reimbursement rate shall be indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (7-1-99)T

43. Inflation Factor. For use in establishing nursing facility rates, the inflation factor is the Skilled Nursing Facility (SNF) Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. (7-1-99)T

44. Interest. The cost incurred for the use of borrowed funds. (1-16-80)

45. Interest On Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are differentiated from those related to current indebtedness by the payback period of the related debt. (1-16-80)

46. Interest On Current Indebtedness. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are differentiated from others by the fact that the related debt is scheduled for repayment within one (1) year. (1-16-80)

47. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (1%) at the date the loan is made. (7-1-99)T

48. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (10-22-93)

49. Intermediary. Any organization which administers the Title XIX program; in this case the Department of Health and Welfare. (1-16-80)

50. Intermediate Care Facility For The Mentally Retarded. A habilitative facility designed and operated to meet the educational, training, habilitative and intermittent medical needs of the developmentally disabled. (9-15-84)

51. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. (1-16-80)

52. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (1-16-80)

53. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (1-16-80)

54. Level Of Care. The classification in which a patient/resident is placed following a medical/social review decision. (1-16-80)

55. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (1-16-80)

56. Lower Of Cost Or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) shall be the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge shall be reimbursed fair compensation; which is the same as reasonable cost. (7-1-99)T

57. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (9-15-84)

58. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (12-28-89)

a. A relatively fixed location in the building; (11-4-85)

b. Capable of being moved, as distinguished from building equipment; (11-4-85)

c. A unit cost of five thousand dollars ($5000) or more; (7-1-99)T

d. Sufficient size and identity to make control feasible by means of identification tags; and (11-4-85)

e. A minimum life of three (3) years. (7-1-99)T

59. **Minimum Data Set (MDS)**. A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of nursing facilities certified to participate in Medicare or Medicaid. The version of the document initially used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (7-1-99)T

60. **Medicaid**. The 1965 amendments to the Social Security Act (P.L. 89-97), as amended. (1-1-

61. **Medicaid Related Ancillary Costs**. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (7-1-99)T

62. **Minor Movable Equipment**. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen shall, at the facility's option, be considered minor movable equipment with the cost thereof reported as a medical supply. The general characteristics of this equipment are: (12-28-89)

a. In general, no fixed location and subject to use by various departments of the provider's facility; (11-4-85)

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (7-1-99)T

c. Subject to inventory control; (11-4-85)

d. Fairly large quantity in use; and (11-4-85)

e. Generally, a useful life of less than three (3) years. (7-1-99)T

63. **Necessary**. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (7-1-99)T

64. **Net Book Value**. The historical cost of an asset, less accumulated depreciation. (1-1-82)

65. **New Bed**. A bed is considered new if it is an additional nursing facility bed that is licensed subsequent to July 1, 1999. (7-1-99)T

66. **Nominal Charges**. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (7-1-99)T

67. **Nonambulatory.** Unable to walk without assistance. (11-4-85)

68. **Nonprofit Organization**. An organization whose purpose is to render services without regard to gains. (1-1-82)

69. **Normalized Per Diem Cost**. Refers to direct care costs that have been adjusted based on the facility's case mix index for purposes of making the per diem cost comparable among facilities. Normalized per diem costs are calculated by dividing the facility's direct care per diem costs by its facility-wide case mix index, and multiplying the result by the statewide average case mix index. (7-1-99)T

70. **Nursing Home Facility**. A "Nursing Facility" or "NF". See facility. (9-28-90)

71. **Nursing Facility Inflation Rate**. The most specific skilled nursing facility inflation rate applicable to Idaho established by Data Resources, Inc. or its successor. If a state or regional index has not been implemented, the national index will be used. (7-1-99)T

72. **Ordinary**. Ordinary means that the costs incurred are customary for the normal operation of the business. (7-1-99)T

73. **Oversight Committee.** The Director will appoint an oversight committee to monitor implementation of the Prospective Payment System (PPS) for nursing facility reimbursement that takes effect July 1, 1999. The committee will be made up of at least one (1) member representing each of the following organizations: the Department, the state association(s) representing free standing nursing facilities, and the state association(s) representing hospital-based nursing facilities. The committee will continue to meet periodically subsequent to the implementation of the PPS. After three (3) years of implementation, the committee will examine the inflation factors used to inflate costs forward for rate setting (DRI + one percent (+1%), the inflation factors used in limiting the growth in the cost component limitations (DRI + two percent (+2%), and the level of the minimum cost component limitations (not lower than limits established July 1, 1999) and report its findings and recommendations to the Director who will, at its option, make changes to the prospective system. (7-1-99)T

74. **Patient Day.** A calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care shall be deemed to exist. (1-1-82)

75. **Picture Date.** A point in time when case mix indices are calculated for every facility based on the residents in the facility on that day. The picture date to be used for rate setting will be the first day of the second month of a quarter. The picture date from that quarter will be used to establish the facility's rate for the next quarter. (7-1-99)T

76. **Private Rate.** Rate most frequently charged to private patients for a service or item. (1-16-80)

77. **PRM.** The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, HCFA Publications 15-1 and 15-2, which are incorporated by reference into these rules. (7-1-99)T

78. **Property Costs.** The total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (9-15-84)

79. **Property Rental Rate.** A rate paid per Medicaid patient day to other than hospital based nursing homes in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/MR facilities. (7-1-97)

80. **Proprietary.** An organization operated for the purpose of monetary gains. (1-16-80)

81. **Provider.** A licensed and certified skilled nursing or intermediate care facility which renders care to Title XIX recipients. (1-16-80)

82. **Prudent Buyer.** A prudent buyer is one who seeks to minimize cost when purchasing an item of standard quality or specification (PRM, Chapter 2100). (7-1-99)T

83. **Public Provider.** A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (7-1-99)T

84. **Related To Provider.** The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (7-1-99)T

85. **Raw Food.** Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (7-1-99)T

86. **Reasonable Property Insurance.** Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year shall not be considered reasonable. (11-4-85)

87. **Recipient**. An individual determined eligible by the Director for the services provided in the state plan for Medicaid. (1-1-82)

88. **Related Entities**. The provider, to a significant extent, is associated or affiliated with, or is controlled by, or has control of another entity. (1-16-80)

89. **Resource Utilization Groups (RUG's).** A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. For purposes of initial rate setting, RUG's III, version 5.12, 34 Grouper, nursing weights only, with index maximization (a Grouper application that assigns a resident to a group whose reimbursement closely approximates the highest case mix index for the resources being provided) will be used for grouping residents and is hereby incorporated into these rules. The RUG's Grouper is available from HCFA, 7500 Security Blvd., Baltimore, MD, 21244-1850. Subsequent versions of RUG's, or its successor, will be evaluated and may be incorporated into the rate setting process as necessary. The Department is under no obligation to incorporate changes to the RUG's Grouper. (7-1-99)T

90. **Skilled Nursing Care.** The level of care for patients requiring twenty-four (24) hour skilled nursing services. (1-16-80)

91. **Skilled Nursing Facility**. A nursing care facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and certified as a "Nursing Facility" under Title XVIII. (9-28-90)

92. **Title XVIII**. The Medicare program administered by the federal Heatlh Care Financing Administration. (1-16-80)

93. **Title XIX**. The medical assistance program known as Medicaid administered by the state of Idaho, Department of Health and Welfare. (1-16-80)

94. **Utilities**. All expenses for heat, electricity, water and sewer. (9-15-84)

005. -- 049. (RESERVED).

050. CRITERIA FOR PARTICIPATION IN THE IDAHO TITLE XIX PROGRAM.

01. Application For Participation And Reimbursement. Prior to participation in the Medicaid Program the Licensure and Certification Section of the Division of Health, Department of Health and Welfare or its successor organization, certifies a facility for participation in the Program. Their recommendations are forwarded to the Division of Welfare, Division of Medicaid or its successor organization, for approval. The Division of Medicaid or its successor organization issues a provider number to the facility which becomes the primary provider identification number. The Division of Medicaid or its successor organization will need to establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. (7-1-99)T

02. Reimbursement. The reimbursement mechanism for payment to provider facilities is specified in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Rules Governing Medical Assistance". The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. (4-28-89)

051. -- 059. (RESERVED).

060. PROPERTY REIMBURSEMENT.

Facilities other than hospital based nursing facilities will be paid a property rental rate, and shall also be reimbursed the Medicaid share of property taxes and reasonable property insurance. The Medicaid share is determined by the ratio of Medicaid patient days to total patient days. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. However, the property rental rate for ICF/MR shall not include compensation for major movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit for a NF, an interim rate for property reimbursement shall be set to approximate the property rental rate as determined by Sections 56-108 and 56-109, Idaho Code. (7-1-97)

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to Section 061., and, beginning April 1, 1985, shall be:

R = "Property Base" x 40 - "Age" / 40 x "change in building costs" where: (12-31-91)

a. "R" = the property rental rate. (11-4-85)

b. "Property Base" = thirteen dollars and nineteen cents ($13.19) beginning October 1, 1996 for all freestanding nursing facilities but not ICF/MR facilities. Beginning October 1, 1996, the property base rate for ICF/MR - living units shall be eleven dollars and twenty-two cents ($11.22) except for ICF/MR living units not able to accommodate residents requiring wheelchairs. Property base = seven dollars and twenty-two cents ($7.22) for ICF/MR living units not able to accommodate residents requiring wheelchairs. (7-1-97)

c. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. Beginning January 1, 1997, "change in building costs" will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs whichever is greater. For freestanding NF facilities, the index available in September of the prior year will be used; for ICF/MR facilities, the most recent index available when it is first necessary to set a prospective rate for a period that includes all or part of the calendar year, will be used.

(7-1-97)

d. "Age" of facility - The effective age of the facility in years shall be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof shall be assigned an age of more than thirty (30) years, however: (11-4-85)

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age shall be set at thirty (30) years. Adequate documentation shall include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age shall be determined for each building. A weighted average using the age and square footage of the buildings shall become the effective age of the facility. The age of each building shall be based upon the date when construction on that building was completed. This age shall be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula:

r	=	A x E / S x C

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 060.01.d.ii.

If the result of this calculation, "r" is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0).(12-28-89)

ii. Historical Nursing Home Construction Cost per Square Foot for Purposes of Evaluating Facility Age.

Age	Year	Cost	Age	Year	Cost	Age	Year	Cost
1	1984	49.72	2	1983	47.61	3	1982	45.99
4	1981	44.51	5	1980	41.77	6	1979	38.58
7	1978	35.20	8	1977	31.54	9	1976	29.43
10	1975	27.38	11	1974	25.17	12	1973	23.58
13	1972	21.37	14	1971	19.57	15	1970	18.27
16	1969	17.52	17	1968	16.32	18	1967	15.41
19	1966	14.86	20	1965	14.22	21	1964	13.87
22	1963	13.65	23	1962	13.20	24	1961	12.90
25	1960	12.77	26	1959	12.58	27	1958	12.23
28	1957	12.05	29	1956	11.84	30	1955	11.32

(10-22-93)

iii. For rates paid after June 30, 1989, the effective age of a facility shall be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 060.01.d.i. However, such change shall not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate "r" for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for "C" shall be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. (10-22-93)

iv. In the event that new requirements are imposed by state or federal agencies, the Department shall reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department shall, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. (7-1-97)

v. At no time shall the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 060.01.d.iii. and 060.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of the financial burden to the state of subsequent property rate increases for a current or successor provider. (7-1-97)

vi. Effective July 1, 1991, for freestanding nursing facilities, and effective October 1, 1996, for ICF/MR facilities, "age of facility" will be a revised age which is the lesser of the age established under other provisions of this Section or the age which most closely yields the rate allowable to existing facilities as of June 30, 1991, under Subsection 060.01 of these rules. This revised age shall not increase over time. (7-1-97)

02. Grandfathered Rate. A "grandfathered property rental rate" for existing free-standing nursing facilities will be determined by dividing the audited allowable annualized property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985, by the total patient days in the period July 1, 1984, through June 30, 1985. (7-1-97)

a. Prior to audit settlement, the interim rate for property costs allowable as of January 1, 1985, shall be used to approximate the grandfathered rate. (11-4-85)

b. The grandfathered property rental rate shall be adjusted to compensate the facility for the property costs of major repairs, replacement, expansion, remodeling or renovation initiated prior to April 1, 1985, and completed during calendar year 1985. (12-28-89)

c. Beginning July 1, 1989, facilities receiving grandfathered rates may have those rates adjusted for modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1986, if the cost of these modifications would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 060.01.d.i. The grandfathered rate shall be revised after completion of modifications and shall be the greater of: (12-31-91)

i. The grandfathered rate previously allowed; or (12-28-89)

ii. The actual per diem property costs of amortization, depreciation and interest not applicable to the modifications for the audit period in which the modifications were completed plus the per diem rate of the first year amortization of the cost of these modifications when amortized over American Hospital Association guideline useful life or lives. However, no change in the grandfathered rate shall be allowed to change that rate by more than three- fourths (3/4) of the difference between the previous grandfathered rate and the property rental rate that would be paid for a new building at the time of the proposed rate revision. (12-28-89)

d. The facility will be reimbursed a rate which is the higher of the grandfathered property rental rate as determined according to provisions of Subsection 060.02 or the property rental rate determined according to Subsections 060.01, 060.03, or 060.05 and Section 061. (12-31-91)

03. Leased Freestanding Nursing Facilities. Freestanding nursing facilities with leases will not be reimbursed in the same manner specified in Subsections 060.01 and 060.02 of these rules. Provisions in this Section do not apply to reimbursement of home office costs. Home office costs shall be paid based on reasonable cost principles. (7-1-97)

a. Facilities with leases entered into on or after March 30, 1981, are to be reimbursed in the same way as owned facilities with ownership costs being recognized instead of lease costs. (11-4-85)

b. Facilities with leases entered into prior to March 30, 1981, will not be subject to reimbursement according to the provisions of Subsections 060.01 or 060.02 or Section 061. Their property rental rate per day of care will be the sum of the annualized allowed lease costs and the other annualized property costs for assets on hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983, through July 1, 1984. (10-22-93)

i. Effective July 1, 1989, the property rental rates of leased nursing facilities (NFs) with leases entered into prior to March 30, 1981, may be adjusted to compensate for increased property costs resulting from facility modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1985, if the cost would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 060.01.d.i. The rate shall be revised after the completion of such modifications and shall be the greater of the property rental rate previously allowed under Subsection 060.03, or the actual per diem property costs for the amortization, depreciation, and interest not applicable to the modifications for the reporting period in which the modifications were completed, plus the per diem of the first year amortization of the modification expenses using the American Hospital Association guideline useful life of lives. However, no such rate change shall increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the previous rate and the property rental rate that would be allowed for a new building at the time of the proposed rate revision. (10-22-93)

ii. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement shall be at a rate per day of care which reflects the increase in the lease rate. (10-22-93)

iii. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement shall be at a rate per day of care which reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters' costs. After April 1, 1985, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by an option to purchase the facility, the property rental rate shall become the amount "R" determined by the formula in Subsection 060.01 as of the date on which the lease is or could be terminated. (10-22-93)

04. Sale Of A Facility. In the event of the sale of a facility, or asset of a facility, the buyer shall receive the property rental rate of Subsection 060.01, except in the event of a forced sale or except in the event of a first sale of a facility receiving a "grandfathered rate" after June 30, 1991, whereupon the property rental rate of the new owner shall be computed as if no sale had taken place. (10-22-93)

05. Forced Sale Of A Facility. In the event of a forced sale of a facility, or asset of a facility, where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, not modified by Section 061, whichever is higher, but not exceeding the rate that would be due the seller. (12-31-91)

061. (RESERVED).

062. PROPERTY REIMBURSEMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR CLASS).
Beginning October 1, 1996, property costs of an ICF/MR shall be reimbursed in accordance with Section 060 of these rules except as follows: (7-1-97)

01. Restrictions. No grandfathered rates or lease provisions other than lease provisions in Section 062 of these rules will apply to ICF/MR facilities. (7-1-97)

02. Home Office And Day Treatment Property Costs. Distinct parts of buildings containing ICF/MR living units may be used for home office or day treatment purposes. Reimbursement for the property costs of such distinct parts may be allowed if these areas are used exclusively for home office or day treatment services. The portion of property cost attributed to these areas may be reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for home office and day treatment property costs shall not include costs reimbursed by, or covered by the property rental rate. Such costs shall only be reimbursed as property cost if the facility clearly included space in excess of space normally used in such facilities. At a minimum to qualify for such reimbursement, a structure would have square feet per licensed bed in excess of the average square feet per licensed bed for other ICF/MR living units within four (4) licensable beds. (7-1-97)

03. Leases For Property. Beginning October 1, 1996, ICF/MR facilities with leases will be reimbursed as follows: (7-1-97)

a. The property costs related to ICF/MR living units other than costs for major movable equipment will be paid by a property rental rate in accordance with Sections 060 and 062 of these rules. (7-1-97)

b. Leases for property other than ICF/MR living units will be allowable based on lease cost to the facility not to exceed a reasonable market rate, subject to other provisions of this chapter, and PRM principles including principles associated with related party leases. (7-1-99)T

063. -- 099. (RESERVED).

100. REASONABLE COST PRINCIPLES.

01. Principle. To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to beneficiaries will result. (1-16-80)

02. Application. (12-31-91)

a. Reasonable costs of any services are determined in accordance with rules found in Sections 250 through 299 and Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (7-1-99)T

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (1-16-80)

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (1-16-80)

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Idaho Code, or are unallowable by application of promulgated regulation. (11-4-85)

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (11-4-85)

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (1-16-80)

03. Costs Related To Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Example: Depreciation is a method of systematically recognizing the declining utility value of an asset. To the extent that the asset is related to patient care, reasonable, ordinary, and necessary, the related expense is allowable when reimbursed based on property costs according to other provisions of this chapter. Property related expenses are likewise allowable. (12-31-91)

04. Costs Not Related To Patient Care. Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. Example: Fines are imposed for late remittance of federal withholding taxes. Such fines are not related to patient care, are not necessary, and are not reflective of prudent cost conscious management. Therefore, such fines and penalties are not allowable. (1-1-82)

05. Form And Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. Example: Lease-Purchase agreements are contracts which are executed in the form of a lease. The wording of the contract is couched in such a manner as to give the reader the impression of a true rental-type lease. However, the substance of this contract is a purchase of the property (see Subsection 354.04.c.iii.). If a lease contract is found to be in substance a purchase, the related payments are not allowable as lease or rental expense. (12-31-91)

101. -- 109. (RESERVED).

110. ALLOWABLE COSTS.
Below is a list of the normally allowable costs, and the related definitions and explanations, which includes, but is not limited to, the following items: (7-1-97)

01. Auto And Travel Expense. Expense of maintenance and operation of a vehicle and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement will not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported on. Meal reimbursement will be limited to the amount that would be allowed by the state for a Department employee. Entertainment expense is allowable only if documentation is provided naming the individuals and stating the purpose of the meeting. Entertainment expense is allowable only for patient care related purposes. (7-1-97)

02. Bad Debts. Payments for efforts to collect past due Title XIX accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX coinsurance amounts are one hundred percent (100%) reimbursable (PRM, Section 300). (7-1-99)T

03. Bank And Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (1-16-80)

04. Contracted Service. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (1-16-80)

05. Depreciation. Depreciation on buildings and equipment is an allowable property expense for hospital-based facilities. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (10-22-93)

06. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (7-1-99)T

07. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (1-16-80)

08. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (7-1-97)

09. Lease Or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, shall be reimbursed in the same manner as an owned asset. The cost of leases related to home offices and ICF/MR day treatment services shall not be reported as property costs and shall be allowable based on reasonable cost principles subject to other limitations contained herein. (7-1-97)

10. Payroll Taxes. The employer's portion of payroll taxes is reimbursable. (1-6-80)

11. Property Costs. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. A property rental rate will be paid in lieu of costs in some circumstances according to other provisions of these rules. (7-1-97)

12. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (11-4-85)

13. Repairs And Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (1-16-80)

14. Salaries. Salaries and wages of all employees engaged in patient care activities or overall operation and maintenance of the facility, including support activities of home offices, shall be allowable. (1-16-80)

15. Supplies. Cost of supplies used in patient care or providing services related to patient care are allowable. (1-16-80)

16. Taxes. Property taxes on assets used in rendering patient care are allowable. Other taxes may be allowable. Specifics are covered in the Provider Reimbursement Manual, PRM, Chapter 21. Tax penalties are not allowable. (7-1-99)T

17. Compensation Of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation shall not exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation shall not exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Sections 402 and 403 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (7-1-97)

a. Salaries wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (7-1-97)

b. Supplies and services provided for the owner's personal use. (1-16-80)

c. Compensation paid by the facility to employees for the sole benefit of the owner. (1-16-80)

d. Fees for consultants, directors, or any other fees paid regardless of the label. (1-16-80)

e. Keyman life insurance. (1-16-80)

f. Living expenses, including those paid for related persons. (1-16-80)

111. -- 114. (RESERVED).

115. NONALLOWABLE COSTS.

In the absence of convincing evidence to the contrary, expenses listed below will be considered nonreimbursable. (1-16-80)

01. Charity Allowances. Cost of free care or discounted services. (1-16-80)

02. Nonpatient Care Related Activities. All activities not related to patient care. (1-16-80)

03. Accelerated Depreciation. Depreciation in excess of straight line except as otherwise provided (see Subsection 354.04.c.ii.). (12-31-91)

04. Related Party Interest. Interest on related party loans (see PRM, Sections 218.1 and 218.2). (7-1-99)T

05. Related Party Nonallowable Costs. All costs not allowable to providers are not allowable to a related party, whether or not they are allocated. (1-16-80)

06. Acquisitions. Cost of corporate acquisitions, e.g., purchase of corporate stock as an investment. (1-16-80)

07. Holding Companies. All home office costs associated with holding companies are not allowable (PRM, Section 2150.2A). (7-1-99)T

08. Related Party Refunds. All refunds, allowances, terms, etc., shall be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. (1-16-80)

09. Fund Raising. Certain fund raising expenses (PRM, Section 2136.2). (7-1-99)T

10. Vending Machines. Costs of vending machines. Barber and beauty shops. (1-16-80)

11. Organization. Organization costs (see PRM, Section 2134 and subsections of Section 2134 for specifics). (7-1-99)T

12. Fees. Franchise fees (PRM, Section 2133.1). (7-1-99)T

13. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services. (7-1-98)

14. Yellow Pages Advertising. Telephone book yellow page advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in. (1-1-82)

15. Consultant Fees. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants and/or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Information obtained from consultants will be provided to facilities. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified pursuant to Subsection 115.15.b., unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This Subsection in no way limits the Department's ability to disallow excessive consultant costs under other Sections of this chapter, such as Section 100 or 121, when applicable. (7-1-97)

16. Goodwill. Costs associated with goodwill as defined in Subsection 003.27 of these rules. (7-1-97)

17. Interest. Interest to finance nonallowable costs. (7-1-97)

18. Property Costs. Costs reimbursed based on a property rental rate according to other provisions of these rules. (7-1-97)

116. -- 119. (RESERVED).

120. HOME OFFICE COST PRINCIPLES.
The reasonable cost principles shall extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, shall provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. (1-1-82)

121. COMPENSATION OF RELATED PERSONS.
Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. (1-1-82)

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. (1-1-82)

a. Where such persons perform services without pay, no cost may be imputed. (1-1-82)

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. (1-1-82)

c. Compensation for undocumented hours worked will not be a reimbursable cost. (1-1-82)

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: (1-1-82)

a. Husband or wife; (1-1-82)

b. Son or daughter or a descendent of either; (1-1-82)

c. Brother, sister, stepbrother, stepsister or descendent thereof; (1-1-82)

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; (1-1-82)

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; (1-1-82)

f. A descendent of a brother or sister of the provider's father or mother; (1-1-82)

g. Any other person with whom the provider does not have an arms length relationship. (1-1-82)

122. LEGAL CONSULTANT FEES AND LITIGATION COSTS.
Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: (1-1-82)

01. In General. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, Office of Audit, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. (1-1-82)

02. Administrative Appeals. In the case of the provider contesting in administrative appeal, the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The extent that the provider prevails will be determined based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. (10-22-93)

03. Other. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law. (1-1-82)

123. OCCUPANCY ADJUSTMENT FACTOR.

In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against property reimbursement paid in lieu of property costs. The adjustment will be made as follows: (11-4-85)

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs will be prorated based upon an eighty percent (80%) occupancy rate. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. (1-1-82)

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. (1-1-82)

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs shall be considered all allowable and reimbursable costs reported under the property cost categories. (11-4-85)

04. Change In Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (1-1-82)

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. (1-1-82)

124. RECAPTURE OF DEPRECIATION.

Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed shall be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. (9-12-86)

01. Amount Recaptured. Depreciation shall be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit shall be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured shall be reduced by ten percent (10%) per year of the total depreciation taken. (1-1-82)

02. Time Frame. Depreciation shall be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. (1-1-82)

125. -- 149. (RESERVED).

150. RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (1-16-80)

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. (7-1-99)T

151. APPLICATION.

01. Determination Of Common Ownership Or Control In The Provider Organization And Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (1-16-80)

a. Common Ownership Rule. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (1-1-82)

b. Control Rule. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise (see control definition in Subsection 151.07). (12-31-91)

02. Cost To Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (1-16-80)

03. Costs Not Related To Patient Care. All home office costs not related to patient care are not allowable under the Program. (1-16-80)

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See PRM and Chapters 2, 10 and 12 for specifics. (7-1-99)T

152. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.
An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary: (1-16-80)

01. Supplying Organization. That the supplying organization is a bona fide separate organization; (1-16-80)

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. (1-16-80)

153. SALES AND RENTAL OF HOSPITALS OR EXTENDED CARE FACILITIES.
The exception is not applicable to sales, lease or rentals of hospital facilities and nursing homes or extended care facilities. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished (PRM, Sections 1008 and 1012). (7-1-99)T

01. Rentals. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (1-16-80)

02. Purchases. When a facility is purchased from a related entity, the purchaser's depreciable basis shall not exceed the seller's net book value (PRM, Section 1005). (7-1-99)T

154. INTEREST EXPENSE.
Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. (7-1-99)T

155. -- 199. (RESERVED).

200. REPORTING SYSTEM.
The objective of the reporting requirements is to provide a uniform system of periodic reports which will allow: (1-16-80)

01. Basis For Reimbursement. A basis of provider reimbursement approximating actual costs. (1-16-80)

02. Disclosure. Adequate financial disclosure. (1-16-80)

03. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis. (1-16-80)

04. Criteria. Criteria for evaluating policies and procedures. (1-16-80)

201. PRINCIPLE.
The provider will be required to file mandatory annual cost reports. Additionally, at his option, he may file cost statements more often to meet cash flow requirements. (12-28-89)

202. APPLICATION.

01. Cost Report Requirements. The fiscal year end cost report filing must include: (12-28-89)

a. Annual income statement (two (2) copies); (1-16-80)

b. Balance sheet; (1-16-80)

c. Statement of ownership; (1-16-80)

d. Schedule of patient days; (1-16-80)

e. Schedule of private patient charges; (1-16-80)

f. Statement of additional charges to residents over and above usual monthly rate; and (1-16-80)

g. Other schedules, statements, and documents as requested. (1-16-80)

02. Cost Statement Requirements. Quarterly and short period cost statement filings must include: (12-28-89)

a. Filed not later than sixty (60) days after the close of the period. Reports received after this time will be accepted at the option of the Department. (1-16-80)

b. Statement of current costs to include at least one (1) quarter (or adjusted quarter, if applicable). Statement may also be filed for any period beginning and ending with quarters of the provider's fiscal year. Other reporting period may be requested. (1-16-80)

c. Schedule of patient days. (1-16-80)

d. Schedule of all patient charges. (1-16-80)

e. Other schedules, statements, and clarifications as requested. (1-16-80)

03. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance. (1-16-80)

04. Criteria. All reports must meet the following criteria: (1-16-80)

a. State approved formats must be used. (1-16-80)

b. Presented on accrual basis. (1-16-80)

c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (1-16-80)

d. Appropriate detail must be provided on supporting schedules or as requested. (1-1-82)

05. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant. (1-16-80)

06. Reporting By Chain Organizations Or Related Party Providers. Section 2141.7, PRM, Providers Reimbursement Manual prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. (7-1-99)T

07. Change Of Management Or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements shall be met: (1-16-80)

a. Outgoing management or administration shall file an adjusted-period cost report. This report shall meet the criteria for annual cost reports, except that it shall be filed not later than sixty (60) days after the change in management or ownership. (12-28-89)

b. Incoming managers or owners shall be required to report on the same basis as a new provider (see Section 203). (12-31-91)

c. The Department may require an appraisal at the time of a change in ownership. (9-15-84)

203. REPORTING PERIOD.
When required for establishing rates, new providers will be required to submit three (3) quarterly cost statements, including one (1) adjusted-quarter report (if applicable), before the annual reporting option may be exercised. If a provider enters the program at some point in midquarter, his first quarter reporting dates will be adjusted to reflect not less than two (2) months operation nor more than four (4). Thereafter the normal reporting period would apply. If a provider withdraws from the program and subsequently re-enters, the new provider reporting requirements will apply. (7-1-99)T

204. FILING DATES.

01. Deadlines. Deadlines for filing quarterly cost statements will be sixty (60) days after the close of the quarter so reported. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. (7-1-97)

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. (7-1-97)

205. FAILURE TO FILE.
Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. (7-1-97)

206. ACCOUNTING SYSTEM.
Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. (1-16-80)

207. AUDITS.
All financial reports are subject to audit by Departmental representatives (see Sections 350 through 399). (12-31-91)

208. REPORTING FORMS.
Unless prior approval is granted, only state forms will be acceptable. Requests for approval of alternate forms must be in writing accompanied by samples. Such requests will not be considered adequate reason for late filing, or granting of a waiver, except in extraordinary circumstances as determined by the intermediary. Following is a partial listing of the account titles used on the state forms. Included also is an explanation of the classification and reporting standards applicable to that account. The report form may be revised periodically to meet changing Department and provider needs and may be in electronic format at the discretion of the Department. Reported costs shall only include allowable costs unless the Department structures the report to remove nonallowable costs by cost groupings, in which case, reported total and subtotal costs shall reflect net allowable costs except for the nonreimbursable section of the report. (7-1-97)

01. Revenues. The categories are self-explanatory. They are intended to give sufficient breakdown of revenues to effect the reasonable cost principles embodied in the cost reporting system. Facilities may also use the cost center approach of the statement to evaluate the expense of certain cost centers in respect to their revenue. (1-16-80)

02. Expenses. (7-1-93)

a. Administrative. (12-31-91)

i. Salaries: Administrator. Included in this category are salaries paid for administrators and assistant administrators of the facility. Any compensation in excess of the amount allowable under other provisions of this chapter shall be entered in the nonreimbursable Section of the cost statement (see Subsection 110.17 of these rules). (7-1-97)

ii. Salaries: Office and Clerical. Salaries and wages paid to clerks, bookkeepers, and others whose duties relate to overall operation of the facility, should be included in this account. (1-16-80)

iii. Payroll Taxes. The provider's portion of payroll taxes for all employees except those taxes related to the payroll for persons providing day treatment services to ICF/MR patients shall be included in the report categories provided for such costs. Payroll taxes for employees providing day treatment services to ICF/MR patients shall be reported in categories provided for these expenses. Self employment taxes related to owners are nonallowable and should not be included. (7-1-97)

iv. Employee Benefits. Expenses incurred such as sick pay and vacation pay should be included in this account except for those expenses relating to persons providing day treatment services for ICF/MR patients. Employee benefits for these employees should be reported in cost categories provided for those expenses. (7-1-97)

v. Accounts Collections. The expenses related to collection of past due program accounts such as legal fees, bill collectors, etc., are allowable. Allowances for bad debts and bad debt write-off are not allowable, and should be included in the Section titled Nonreimbursable Expenses. (4-28-89)

vi. Auto and Travel. These expenses shall be those incurred in the operation of vehicles and other travel expense related to patient care. Normally, entertainment shall not be involved, but shall be recorded in the Section under Nonreimbursable Expenses (see PRM, Chapter 21). (7-1-99)T

vii. Bank and Finance Charges. Normally recurring minor charges for handling of accounts shall be included here. (1-16-80)

viii. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care or for general patient use, license fees (not including franchises), and dues to professional health care organizations are to be included. Dues, tuitions and educational fees to facilitate quality health care services are includable where the provisions of PRM, Section 400, are met. (7-1-99)T

ix. Employee Recruitment. Costs of advertising for new employees shall be recorded in this account including applicable entertainment costs. (1-16-80)

x. Home Office Costs. Costs allocated by related entities for various services shall be included in this account. (1-16-80)

xi. Malpractice/Public Liability Insurance. Premiums for malpractice and public liability insurance shall be included in this account. (1-16-80)

xii. Purchased Services. Costs of legal, accounting, and management services (not including related entities) for overall operations shall be included in this account. (1-16-80)

xiii. Supplies and Rentals. Cost of supplies, postage, ledger sheets, and rental of minor office equipment shall be included in this account. (1-16-80)

xiv. Telephone and Communications. Cost of telephone and related communications shall be included in this account. (1-16-80)

xv. Interest, Working Capital. Allowable interest expense for loans not related specifically to the purchase of the real or personal property of the provider shall be reported here. (1-1-82)

xvi. Miscellaneous. Any expense not properly allocable to other cost centers and not properly classified in other classification of administration expenses shall be included here. (1-16-80)

b. Property. Property costs shall be reported by all facilities including those facilities which are reimbursed a property rental rate. (11-4-85)

i. Amortization. Amortization of leasehold improvements shall be included here. Certain others may be included here also. (1-16-80)

ii. Depreciation on Fixed Assets. Depreciation expenses for buildings and fixtures should be included here. Any depreciation in excess of straight line AHA lives shall not be included unless otherwise waived by the Department. Such excess shall be included in the Section of Nonreimbursable Expenses. (7-1-97)

ii. Depreciation of Equipment. Depreciation expense for moveable equipment shall be included here. Excess depreciation as defined above shall be included in the Nonreimbursable Section (see Subsection 354.04.c.). (12-31-91)

iv. Interest Expense. Interest expense related to purchase of land, buildings and equipment related to patient care shall be included here only if it is payable to unrelated entities. Generally, interest payable to related entities shall be included in the Nonreimbursable Section (PRM, Section 202.3). (7-1-99)T

v. Insurance. Insurance premiums for property insurance such as fire and glass shall be includable here. (1-16-80)

vi. Lease and Rental Payments. Payments for lease or rental of buildings, land and for equipment shall be includable here. (1-16-80)

vii. Taxes. Taxes on property related to patient care shall be recorded in this account. (1-16-80)

c. Patient Care Service. (1-16-80)

i. Nursing Care. (1-16-80)

(1) Salaries. Director of Nursing. Salaries or wages of the Director of Nursing shall be included here. (1-16-80)

(2) Registered Nurse. Salaries and wages of registered nurses shall be included in this account. Payroll taxes shall not be included but overtime shall be. (1-16-80)

(3) Licensed Professional Nurses. Wages for licensed professional nurses shall be included in this account including overtime, but not including payroll taxes. (1-16-80)

(4) Aides/Orderlies. Normal overtime and wages for aides and orderlies, not to include payroll taxes, shall be included in this account. (1-16-80)

(5) Contracted Services. Payments for patient health care services under contract shall be entered here. (1-16-80)

ii. Therapy Services. (1-16-80)

(1) Salaries. Salaries for all therapy personnel shall be recorded here. (1-16-80)

(2) Professional Services. Payments for contracted therapy services shall be recorded here. (1-16-80)

(3) Supplies and Miscellaneous. Expenses for supplies and miscellaneous expenses related to therapy and recreational therapy services shall be recorded here. (1-16-80)

iii. Social Services. (1-16-80)

(1) Salaries. Wages and salaries for activity directors and social services personnel shall be recorded here. (1-16-80)

(2) Contracted Services. Payments under contract arrangement for activities director or other social services personnel shall be included here. (1-16-80)

iv. Payroll Taxes and Employee Benefits. The payroll taxes and cost of employee benefits related to the salaries reported in Section 208 of these rules should be reported here. (7-1-97)

v. Costs Not Subject to the Percentile Cap. (12-31-91)

(1) Special Needs. Those costs determined by the Department and authorized under Section 56-117, Idaho Code, will be excluded from other reported costs and will be reported here (see Subsection 254.08). (12-31-91)

(2) Excluded Costs. Increases in costs otherwise subject to a cap incurred by facilities as a result of changes in legislation or regulations will be excluded from costs reported in categories subject to the cap and will be reported here (see Subsection 254.09). (7-1-97)

d. Facility Operations and Services. (1-16-80)

i. Central Supply. (1-16-80)

(1) Salaries: Pharmacist. Salaries and wages of pharmacists who are regular employees of the facility shall be included here, but are not reimbursable. (1-16-80)

(2) Salaries. Salaries and wages of others, such as stock clerks, shall be recorded here. (1-16-80)

(3) Contracted Services. Payments for services under contract will be recorded in this category, not including pharmaceutical services. (1-16-80)

(4) Supplies and Miscellaneous. Miscellaneous expenses and routine nursing supplies such as laxatives, aspirin, and dressings shall be recorded here; the cost of oxygen concentrators may also be recorded here. Cost of prescription drugs must not be included. (12-28-89)

ii. Laundry and Linen. (1-16-80)

(1) Salaries. Salaries and wages for personnel involved in laundry operations shall be recorded here. (1-16-80)

(2) Purchased Services. Costs of contracted linen services shall be recorded here. (1-16-80)

(3) Linens and Bedding. Purchase of sheets, mattress pads, blankets, towels, etc., shall be entered here. Costs of beds and mattresses are capitalizable and should be treated accordingly. (1-16-80)

(4) Miscellaneous Expenses. Miscellaneous expenses not properly classified in other areas of Section 208 should be included in this account. (12-31-91)

e. Dietary. (1-16-80)

i. Salaries: Dietitian. Wages of a dietitian who is a regular employee shall be included here. (1-16-80)

ii. Salaries: Other. Salaries of cooks and other dietary personnel should be recorded here. (1-16-80)

iii. Purchased Services. Payments for contracted dietary services, or dietitians, shall be included here. (1-16-80)

iv. Food. Cost of food used for the period will be included here not including vending machine items. For purposes of reasonable cost evaluation, revenues from meals sold to nonpatients will reduce food costs and should be reported in the revenue Section. (1-16-80)

v. Supplies. Cost of dietary supplies other than food should be recorded here. Do not include vending machine items. (1-16-80)

f. Plant Operations and Maintenance. (1-16-80)

i. Salaries. Wages of all housekeeping and maintenance employees shall be included in this account. (1-16-80)

ii. Repairs and Maintenance. Cost of minor repairs to buildings and equipment shall be recorded here. (1-16-80)

iii. Purchased Services. Costs of maintenance and repair services purchased under contract arrangements shall be recorded here. 1-16-80)

iv. Utilities. Expenses for heat, electricity, water and sewer shall be included in this account. (9-15-84)

v. Supplies and Miscellaneous. Expense of supplies and other unclassified expenses should be included here. (1-16-80)

g. Nonreimbursable Expenses. This classification of expenses is provided to reconcile your cost statement to books of record. It will also help the facility to determine its reasonable costs and anticipate its revenues. Routine business expenses not includable in the reasonable cost formula are to be recorded in Section 208. The account titles are indicative of these costs which are commonly found. (12-31-91)

03. Home Office Reporting. The purpose of the provisions of Section 208, is to support the costs allocated to the provider facility. A report is required for each level of organization which allocates costs to the provider, directly or indirectly. (7-1-97)

209. -- 239. (RESERVED).

240. PROSPECTIVE RATES FOR ICF/MR.

Sections 240 through 247 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/MR providers. Total payment will include

following components: Property reimbursement, capped costs, an efficiency increment, exempt costs, excluded costs. Notwithstanding the provisions of Section 56-113, Idaho Code, it is the intent of the Idaho Legislature that for the period July 1, 2000, through June 30, 2002, rates, including special rates of private intermediate care facilities for the mentally retarded, shall not exceed the rates in effect in state fiscal year 2000 (July 1, 1999 through June 30, 2000).

241. PRINCIPLE.
Providers of ICF/MR facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider will report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM to the extent not inconsistent with this chapter.

242. PROPERTY REIMBURSEMENT.
Beginning October 1, 1996, ICF/MR property costs are reimbursed by a rental rate or based on cost. The following shall be reimbursed based on cost as determined by the provisions of this chapter and applicable provisions of PRM to the extent not consistent with this chapter: ICF/MR living unit property taxes, ICF/MR living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and shall not be reported in the property cost portion of the cost report. These costs shall be reported in the home office and day treatment section of the cost report. Property costs, including costs which are reimbursed based on a rental rate, shall be reported in the property cost portion of the cost report. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. Property costs include the following components:

01. Depreciation. Allowable depreciation based on straight line depreciation.

02. Interest. All allowable interest expense which relates to financing depreciable assets. Interest on working capital loans is not a property cost and is subject to the cap.

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances are not property costs.

04. Lease Payments. All allowable lease or rental payments.

05. Property Taxes. All allowable property taxes.

06. Costs of Related Party Leases. Costs of related party leases are to be reported in the property costs categories based on the owner's costs.

243. ICF/MR CAPPED COST.
Beginning October 1, 1996, this cost area includes all allowable costs except those specifically identified as property costs in Section 242 and exempt costs or excluded costs in Section 246 or 247 of these rules. This Section defines items and procedures to be followed in determining this limit and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/MR cap.

01. Costs Subject to the Cap. Items subject to the cap include all allowable costs except property costs identified in Section 242 and exempt costs or excluded costs identified in Section 246 or 247 of these rules. Property costs related to a home office are administrative costs, shall not be reported as property costs, and are subject to the cap.

02. Per Diem Costs. Costs to be included in this category will be divided by the total patient days for the facility for the cost of reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for the purpose of determining the ICF/MR cap and for computing final reimbursement.

03. Cost Data To Determine The Cap. Cost data to be used to determine the cap for ICF/MR facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department. (7-1-97)

04. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the same table as used for free standing facilities in Subsection 254.04.a. of these rules. (7-1-97)

a. The projection method used in this Section to set the cap will also be used to set non property portions of the prospective rate which are not subject to the cap. (7-1-97)

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. (7-1-97)

05. Costs Which Can Be Paid Directly By The Department To Non ICF/MR Providers. Costs which can be paid directly by the Department to non ICF/MR providers are excluded from the ICF/MR prospective rates and ICF/MR cap: (7-1-97)

a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers. (7-1-97)

b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. These services are enumerated in IDAPA 16 Title 03, Chapter 09, "Rules Governing Medical Assistance," and include such items and services as eyeglasses, hearing aids, and dental services provided to Medicaid recipients under the age of twenty-one (21). The cost of these services is not includable as a part of ICF/MR costs. Reimbursement can be made to a professional providing these services through his billing the Medicaid Program on his own provider number. (7-1-97)

c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items must be billed to the Medicaid Program directly by the provider using his own provider number. (7-1-97)

06. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base Period to the midpoint of the Target Period. "Base Period" is defined as the last available final cost report period. "Target Period" is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows: (7-1-97)

a. The percentage change for each cost category in the market basket will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period. (7-1-97)

b. The percentage change for each cost category in the market basket will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 243.06.a. of these rules, from the end of the Base Period to the beginning of the Target Period. (7-1-97)

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant

percentages will be used to project forward the allowable per diem costs as determined in Subsection 243.06.b. of these rules from the beginning to the midpoint of the Target Period. (7-1-97)

07. Cost Ranking. Prior to October 1 of each year the Director will determine that percent above the median which will assure aggregate payments to ICF/MR providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30 of each year. Projected per diem costs as determined in this Section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. (7-1-97)

a. The median of the range will be computed based on the available data points being considered as the total population of data points. (7-1-97)

b. The cap for each ICF/MR facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. (7-1-97)

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 245 of these rules apply. (7-1-97)

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. (7-1-97)

e. A new cap and rate will be set for each facility's fiscal year after September 30, 1996. (7-1-97)

f. The cap and prospective rate will be determined and set for each facility's upcoming fiscal year prior to that year and it will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. (7-1-97)

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 247 of these rules apply. (7-1-97)

h. A facility which commences to offer patient care services as an ICF/MR on or after October 1, 1996, shall be subject to retrospective settlement until the first prospective rate is set. Such facility shall be subject to the ICF/MR cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period. (7-1-97)

244. EFFICIENCY INCREMENT FOR ICF/MR.
An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap. (7-1-99)T

01. Computing Efficiency Increment. The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents ($.20) per one dollar ($1) below the cap up to a maximum increment of three dollars ($3) per patient day. (7-1-97)

02. Determining Reimbursement. Total reimbursement determined by adding amounts determined to be allowable, shall not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and PRM. In computing patient days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the patient is making payment for holding a bed in the facility, the patient will not be considered to be discharged and thus those days will be counted in the total. (7-1-99)T

245. RETROSPECTIVE SETTLEMENT.
When retrospective settlement is applicable, it is based on allowable reimbursement in accordance with this chapter and based on an audit report. Retrospective settlement will be subject to the same caps and limits determined for prospective payments. (7-1-97)

01. A Provider's Failure To Meet Any Of The Conditions. A provider's failure to meet any of the conditions of participation set forth in 42 CFR 483, Subpart I, may subject that provider to retrospective reimbursement for the fiscal year, or any portion thereof, during which the condition is not met. The provider's projected per diem rate may be adjusted to reflect actual reimbursable costs subject to cost limits. (7-1-97)

02. A First Time Provider. A first time provider operating a new ICF/MR living unit will be subject to a retrospective settlement for the first fiscal year and until the first subsequent period wherein a prospective rate is set in accordance with Sections 203, 204, and 243 and this chapter. A budget based on the best available information is required prior to opening for patient care so an interim rate can be set. (7-1-97)

03. New ICF/MR Living Unit. A new ICF/MR living unit for an existing operator is subject to first time facility requirements if the new living unit reflects a net increase in licensed beds, otherwise the Department may set a prospective rate with the nonproperty rate components based on similar components of rates most recently paid for the patients moving into the facility. The property rental rate will be set according to applicable provisions of this chapter. (7-1-97)

04. Change Of Ownership Of Existing ICF/MR Living Unit. Where there is a change of ownership of an existing ICF/MR living unit, the provider operating the ICF/MR living unit will not receive an adjustment of the provider's prospective rate except that the property rental portion of the rate will be adjusted subject to property rental provisions of this chapter. However, new facility reporting requirements and the cap will apply. (7-1-97)

05. Fraudulent Or False Claims. Providers who have made fraudulent or false claims are subject to retrospective settlement as determined by the Department. (7-1-97)

06. Excluded Costs. Excluded costs may be retrospectively settled according to the provisions of Section 247 of these rules. (7-1-97)

246. EXEMPT COSTS.

Exempt costs are not subject to the ICF/MR cap. (7-1-97)

01. Day Treatment Services. As specified in this Section, the cost of day treatment services may be reimbursed in this category and may not be subject to the ICF/MR cap. (7-1-97)

a. This category includes the direct costs of labor, benefits, contracted services, property, utilities and supplies for such services up to the limitations provided in this Subsection. (7-1-97)

b. When a school or another agency or entity is responsible for or pays for services provided to a patient regularly during normal working hours on weekdays, no costs will be assigned to this category for such services. The Department will not reimburse for the cost of services which are paid for or should be paid for by an other agency. (7-1-97)

c. When ICF/MR day treatment services are performed for patients in a licensed Developmental Disability Center, the allowable cost of such services shall be included in this category, but not more than the amount that would be paid according to the Department's fee schedule for individual or group therapy for similar services. Amounts incurred or paid by the ICF/MR in excess of what would be paid according to the Department's fee schedule for like services are not allowable costs and shall be reported as nonreimbursable. (7-1-97)

d. For day treatment services provided in a location other than a licensed developmental disability center, the maximum amount reportable in this category shall also be limited. Total costs for such services reported by each provider in this category shall be limited to the number of hours, up to thirty (30) hours per week per client, of individual or group developmental therapy times the hourly rate that would be paid according to the most recent Department fee schedule for the same services if provided in a developmental disability center. Costs in excess of the limits determined in this Subsection shall be classified and reported as subject to the ICF/MR cap. Initial rates established under the prospective system effective October 1, 1996, and not later than October 1, 1997, will not include a limitation of day treatment costs based on the hourly rate, when the hours of individual or group therapy were not obtained or audited by the Department at the time the rate was published. However, if a provider believes that the day treatment cost used to establish the day treatment portion of its prospective rate was misstated for rates set for periods beginning October 1, 1996, through rates beginning October 1, 1997, revisions to the prospective rate may be made to the extent the provider demonstrates, to the satisfaction of the Department, that the cost used was misstated. Such a revision will be considered only if the provider requests a revision and provides adequate documentation within sixty (60) days of the date the rate was set. At the option of the Department it may negotiate fixed rates for these day treatment services. Such rates shall be set so the aggregate related payments are lower than would be paid with a limitation based on schedules used for licensed Developmental Disability Centers. (7-1-97)

e. Financial data including expenses and labor hours incurred by or on behalf of the provider in providing day treatment services, must be identifiable and separate from the costs of other facility operations. Reasonable property costs related to day treatment services and not included in the property rental rate, shall be separately identified, shall be reported as day treatment services costs, and shall not include property costs otherwise reimbursed. Property costs related to day treatment services shall be separately identified as not related to living unit costs by a final audit determination issued prior to October 1, 1996, or shall be separate and distinct from any property used for ICF/MR services which are or were day treatment services. (7-1-97)

f. In the event a provider has a change in the number of patients requiring day treatment services, the prospective rate may be adjusted by the Department to reflect a change in costs related to such a change. Providers receiving such changes may be required to provide added documentation to the Department to assure that further changes can be identified and the prospective rate adjusted accordingly. (7-1-97)

02. Major Movable Equipment. Costs related to major movable equipment, as defined in this chapter shall be exempt from the ICF/MR cap and shall be reimbursed prospectively based on Medicare principles of cost reimbursement. (7-1-97)

247. COSTS EXCLUDED FROM THE CAP.

Certain costs may be excluded from the ICF/MR cap, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rate as provided in this Section to assure equitable reimbursement: (7-1-97)

01. Increases Of More Than One Dollar Per Patient Day In Costs. Increases of more than one dollar ($1) per patient day in costs otherwise subject to the cap incurred by a facility as a result of changes in State or Federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the cap. The Department may adjust the forecasted rate to include the projected per diem related to such costs. (7-1-97)

a. The provider shall report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. (7-1-97)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. (7-1-97)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-97)

c. For interim rate purposes the provider's prospective rate may be granted an increase to cover such cost increases. A cost statement covering a recent period may be required with the justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-97)

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases with costs subject to the cap when setting rates or increase the cap and individual facility prospective rates following such cost increases. If a cap is set with these particular costs included in the cap category, providers subject to that cap will not have these costs excluded from the cap for prospective rate purposes. The intent of this provision is for costs to be exempt from the cap until these costs are able to be fully and equitably incorporated in the data base used to project the cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. (7-1-97)

f. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cap, the cost indices will be adjusted to exclude the influence of such changes if the amount is included in the index is identified. When the cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. (7-1-97)

02. Excess Inflation. Reimbursement of costs subject to the cap will be limited to the cap unless the Department determines the inflation indices used to set the prospective rates for a reporting period understated actual inflation by more than seven (7%) percentage points. In such case, prospective rates and the cap will be increased by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the department. (7-1-97)

03. Cost Increases Greater Than Three Percent. Cost increases greater than three percent (3%) of the projected interim rate which result from disasters such as fire, flood, or earthquake, epidemic or similar unusual and unpredictable circumstances over which a provider has no control. In such case, prospective rates will be increased and will not be subject to the cap, by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the Department for purposes of this Subsection. Disaster does not include personal or financial problems. (7-1/-97 "P & I"

04. Decreases. In the event of state or federal law, rule, or Policy changes which result in clearly identifiable reductions in required services, the Department may reduce the prospective rate to reflect the identified per diem amount related to such reductions. (7-1-97)

05. Prospective Negotiated Rates. Notwithstanding the provisions of Sections 240 through 246, the Director shall have the authority to negotiate prospective rates for providers who would otherwise be subject to accept retrospective settlement. Such rates shall not exceed the projected allowable rate that would otherwise be reimbursed based on provisions of this chapter. (7-1-97)

248. SPECIAL RATES FOR ICF'S/MR

Section 56-117, Idaho Code, provides authority for the Director to pay facilities a special rate for care given to consumers who have long term care needs beyond the normal scope of facility services. These individuals must have one or more of the following behavior needs; additional personnel for supervision, additional behavior management, or additional psychiatric or pharmacology services. A special rate may also be given to consumers having medical needs that may include but are not limited to individuals needing ventilator assistance, certain medical pediatric needs, or individuals requiring nasogastric or intravenous feeding devices. These medical and behavior needs are not adequately reflected in the rates calculated pursuant to the principles set forth in Section 56-113, Idaho Code. The payment for such specialized care will be based on a per diem rate applicable to the incremental additional costs incurred by the facility. Payment for special rates will start with approval by the Department and be and reviewed at least yearly for continued need. The incremental cost to a facility that exceeds the rate for services provided ursuant to the provisions of Section 248, will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement". (2-15-00)T

01. Determinations. A determination to approve or not approve a special rate will be made on a consumer-by-consumer basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source.(2-15-00)T

02. Approval. Special Rates will not be paid unless prior authorized by the Department. A special rate may be used in the following circumstances: (2-15-00)T

a. New admissions to a community ICF/MR, (2-15-00)T

b. For individuals currently living in a community ICF/MR when there has been a significant change in condition not reflected in the current rate, or (2-15-00)T

c. The Facility has altered services to achieve and maintain compliance with State Licensing or Federal certification requirements that have resulted in additional cost to the facility not reflected in their current rate. (2-15-00)T

d. For the purpose of this rule, an emergency exists when the facility must incur additional behavioral or medical costs to prevent a restrictive placement. (2-15-00)T

03. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (2-15-00)T

04. Limitations. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services. (2-15-00)T

249. RESERVED

250. COST LIMITS FOR NURSING FACILITIES.
Sections 250 through 312 of these rules, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56- 135, Idaho Code. All audits related to fiscal years ending on or before December 31, 1999 are subject to rules in effect before July 1, 1999. (7-1-99)T

251. PRINCIPLE.
Providers of nursing home services will be paid at the allowed amount determined in accordance with Section 56-101 to 56-131, Idaho Code. Total payment will be made up of the total of the following components: (7-1-99)T

01. Property And Utility Costs. All allowable property and utility costs; (9-15-84)

02. Nonproperty, Nonutility Costs. Nonproperty nonutility costs as determined in accordance with the above mentioned Sections of the Idaho Code. (9-15-84)

03. Efficiency Increment. An efficiency increment determined in accordance with the above mentioned Sections of the Idaho Code. (1-1-82)

04. Exempt Costs. Other allowable costs exempt from the percentile cap under Sections 56-110(b) and 56-117, Idaho Code, as specified in Subsection 254.08 and 254.09. (12-31-91)

252. PROPERTY AND UTILITY COSTS.
The allowability of each of these cost items will be determined in accordance with other provisions of this chapter, or the PRM in those cases where this the rules of this chapter are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (7-1-99)T

01. Depreciation. All allowable depreciation expense. (1-1-82)

02. Interest. All allowable interest expense relating to financing building and equipment purchases. Interest on working capital loans will be included as administrative costs. (1-1-82)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs. (1-1-82)

04. Lease Payments. All allowable lease or rental payments. (1-1-82)

05. Property Taxes. All allowable property taxes. (1-1-82)

06. Utility Costs. All allowable expenses for heat, electricity, water and sewer. (9-15-84)

253. -- 299. (RESERVED).

300. RATE SETTING.
The objectives of the rate setting mechanism for nursing facilities are: (7-1-97)

01. Payments. To make payments to nursing facilities through a prospective cost-based system which includes facility-specific case mix adjustments. (7-1-99)T

02. Rate Adjustment. To set rates based on each facility's case mix index on a quarterly basis and establishing rates that reflect the case mix of that facility's Medicaid residents as of a certain date during the preceding quarter. (7-1-99)T

301. PRINCIPLE.

Reimbursement rates will be set based on projected cost data from cost reports and audit reports. Reimbursement is to be set for freestanding and hospital-based facilities. In general, the methodology will be a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. (7-1-99)T

302. DEVELOPMENT OF THE RATE.

Rates shall be rebased annually. Rate setting shall be prospective with new rates effective July 1 of each year. There will be no settlement between actual costs incurred during the rate year and the rate itself. Rates for nursing facilities with unaudited cost reports will be interim rates established by the Department until a rate is calculated based on an audited cost report. The draft audit of a cost report submitted by a facility shall be issued by the Department no later than five (5) months from the date all information required for completion of the audit is filed with the Department. Data used to develop the reimbursement rate for nursing facilities will be made up of the following components: (7-1-99)T

01. Property Reimbursement. Per diem property costs as shown on the latest twelve (12) month cost report or audit report whichever is to be used in accordance with the cost reporting standards specified in Subsection 302.07. and the property rental rate as determined by Section 060, for facilities which receive this rate in lieu of property costs. No inflationary increase will be considered for property costs for the purpose of developing the interim rate. The property reimbursement component will be calculated in accordance with Section 060 of these rules. (7-1-99)T

02. Utility Costs. Projected utility costs for the facility's upcoming fiscal year may be submitted to the Department not less than ninety (90) days prior to the beginning date of the facility's upcoming fiscal year. In the absence of such submission the Department will project the facility's utility costs utilizing the methodologies found in Subsection 302.07. (7-1-99)T

03. Direct Care Component. The direct care component of a facility's rate is the lesser of the facility's inflated direct care costs per resident day as defined in subsection 004.27 and for the cost report period discussed in subsection 302.07 adjusted for inflation in accordance with subsection 004.42 and 004.43 or the direct care cost limit discussed in subsection 303.02 for that type of provider (free-standing nursing facility and urban hospital-based nursing facility, or rural hospital-based nursing facility). The lesser of the inflated direct care costs per resident day subject to subsection 302.03.a or the applicable direct care cost limit also subject to subsection 302.03.a and as adjusted in subsection 302.03.b is then case mix adjusted, based in the facility's Medicaid case mix index as discussed in subsection 302.03.c. (7-1-99)T

a. All costs included in the direct care component will be adjusted based on the facility's case mix indices, with the exception of raw food and Medicaid related ancillary costs. (7-1-99)T

b. The direct care cost limits will be adjusted based on each facility's case mix index. The calculated direct care cost limit will be divided by the statewide average facility-wide case mix index, and then multiplied by the individual facility-wide case mix index. (7-1-99)T

c. The lesser of the inflated direct care costs per resident day or the applicable direct care cost limit will be divided by the facility-wide case mix index, and then multiplied by the most recent quarterly Medicaid case mix index to arrive at the direct care component. (7-1-99)T

04. Indirect Care Component. The indirect care component of a facility's rate is the lesser of the facility's inflated indirect care costs per resident day as defined in subsection 004.41 and for the cost reprot period discussed in aubsection 302-07 adjusted for inflation in accordance with subsection 004.42 and 004.43, or the indirect care cost limit for that type of provider (freestanding nursing facilities and urban hospital-based facilities, or rural hospital-based facilities). (7-1-99)T

05. Efficiency Incentive. The efficiency incentive is available to those providers, both freestanding and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that

type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by seventy percent (70%). There is no incentive available to those facilities with per diem costs in excess of the indirect care limit, or to any facility based on the direct care component. (7-1-99)T

06. Calculated Reimbursement Rate. The reimbursement rate for a facility will be the sum of the Direct Care Component, Indirect Care Component, Efficiency Incentive, Cost Exempt from Limitation, and Property Reimbursement. In no case will the prospective reimbursement rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is being made as computed by the lower of costs or customary charges. (7-1-99)T

07. Cost Component. The cost component of each facility's rate shall be established effective July 1 of each year and remain in effect through the following June 30. The cost data used in establishing the cost component of the rate calculation will be from the audited or unaudited cost report which ended during the previous calendar year (i.e., cost reports ending during the period from January 1, 1998 - December 31, 1998 will be used in setting rates effective July 1, 1999). If unaudited data is used, the rate will be considered an interim rate until the audited data is available, at which time a retroactive adjustment to the payment rate will be made. (7-1-99)T

08. Case Mix Component. The Medicaid case mix indices used in establishing each facility's rate will be recalculated quarterly and each facility's rate will be adjusted accordingly. The case mix indices will be calculated based on the most recent assessment for each resident in the facility on the first day of the second month of the preceding quarter (i.e., assessments as of May 1, 1999 would be used to establish the case mix indices needed to establish rates for the quarter beginning July 1, 1999. (7-1-99)T

303. COST LIMITS.

Effective July 1, 1999, and each July 1 thereafter, the direct care and indirect care components shall be subject to cost limits. The cost limits shall be based on the most recent audited cost report with an end date of June 30 of the previous year or before (the base year), and will be effective for a one-year period. Each component shall have two cost limits, one applicable to both free-standing and urban hospital-based nursing facilities and the second for rural hospital based nursing facilities. (7-1-99)T

01. Basis for the Costs Limits. Prior to establishing the first "shadow rates" (the prospective rates at July 1, 1999), Medicaid payments for the period from July 1, 1999 through June 30, 2000 shall be calculated using the previous retrospective system. This calculation shall be used to establish the cost limits effective July 1, 1999specifically, to provide that the direct and indirect care components of the prospective rates reflect the following: (7-1-99)T

a. A level of Medicaid expenditures that approximates the same amount under the retrospective system.
b. The same distribution of total Medicaid dollars between the hospital-based and free-standing nursing facilities.
c. That direct care costs are higher than indirect care costs.
d. That rural hospital-based nursing facilities shall have higher cost limits than free-standing and urban hospital-based nursing facilities.

Once established, the percentage calculated as a result of these conditons will remain in effect for future rate setting periods.

02. Direct Cost Limits. 02. Direct Care Cost Limits. Direct care costs as defined in §§004.27 for the base year shall be adjusted for inflation in accordance with §§004.42 and .43. Inflation adjusted direct care costs (excluding ancillary and raw food costs) per resident day are next "normalized" to make these costs comparable among facilities. In accordance with §§004.69 the normalized costs per resident day are derived by dividing each facility's inflation adjusted cost per resident day excluding ancillary and raw food costs by its facility-wide case mix index (¶004.12.a) for the base year and multiplying the results by the state-wide average case mix index (¶004.12.c). Direct care ancillary and food costs are not subject to case mix adjustments. However, in determining the direct

care component of a facility's prospective payment rate, all direct care costs are case mix adjusted per ¶302.03.c. To reverse this effect, in determining the direct care cost limits, the inflation adjusted ancillary and raw food costs per resident day are adjusted by the quotient of the facility wide case mix index divided by the facility's Medicaid case mix index for the base year. The total direct care costs per resident day (the case mix adjusted costs per resident day plus the adjusted ancillary and raw food costs per resident day) are then arrayed (sorted) from the highest to the lowest. A cumulative bed level is determined for each facility, beginning with that facility with the highest total direct care costs per resident day. The number of licensed beds for that facility are added to the number of beds of the next highest cost facility, resulting in a bed level for the second facility consisting of the number of its beds plus the number of beds of the highest total direct care cost perdiem. This sequential cumulation continues until the facility with the lowest total direct cost perdiem is included and a total bed level is determined. A median bed level shall be determined and the total direct care costs per resident day for the facility at the median bed level becomes the basis for the direct care cost limits. The direct care cost limits shall be determined by applying the conditions described in §§303.01 to the total direct care costs per resident day of the facility at the median bed level. (7-1-99)T

03. Indirect Cost Limits. Indirect care costs as defined in §§004.42 and for the same reporting year used to determine the direct cost limits shall be adjusted for inflation. To arrive at the indirect care costs, indirect care costs for ancillary services in the base year cost report were Medicaid specific and an adjustment had to be made to arrive at a facility-wide level. The methodology used to determine the direct care cost limits excluding normalizing per resident day and case mix adjustments, but including arraying the costs per resident day, identifying that costs per resident day at the median bed level, and subjecting that Costs per resident day to the conditions described in §§303.01 shall also be employed to determine the indirect care cost limits. (7-1-99)T

04. Limitation On Increase Or Decrease Of Cost Limits. Increases in the direct and indirect cost limits shall be determined by the limitations calculated effective July 1, 1999, indexed forward each year by the inflation factor plus two percent (2%) per annum. Furthermore, the calculated direct and indirect cost limits shall not be allowed to decrease below the established limitations effective July 1, 1999. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee after a three-year period to determine which factors to use in the calculation of the limitations effective July 1, 2002 and forward. (7-1-99)T

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 123. (7-1-99)T

304. TREATMENT OF NEW BEDS.

Facilities which add beds subsequent to the effective date of these rules (July 1, 1999), will have their reimbursement rates subjected to an additional limitation for the next three (3) full years. This limitation will apply beginning with the first rate setting period that utilizes a cost report that includes the date(s) when the beds were added and will be re-determined each July 1 thereafter. The facility's rate will be limited to an average of two rates (2). The calculation is as follows: (7-1-99)T

01. Calculation of the New Bed Rate. The number of beds in existence prior to the additions will be multiplied by 365 or 366 (the number of days in the cost report year). The resulting total days will then be multiplied by the current payment rate calculated in accordance with §302. Each new bed will be multiplied by the number of days in the cost reporting period that the bed was in service. The total number of days for all new beds will then be multiplied by the current median rate for facilities of the same type (freestanding, urban hospital-based, or rural hospital-based). The sum of the amounts calculated in §§304.1 and §§304.02 will then be divided by the sum of the total days applicable to beds in existence prior to the addition and the new beds. The resulting per diem will represent an overall limitation on the facility's reimbursement rate. Providers with rates calculated in accordance with §302 that do not exceed the limitation will receive their calculated rates. (7-1-99)T

a. Exception To New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes: (7-1-99)T

b. Any beds converted from nursing facility to assisted living beds may not be reclassified to new nursing facility beds until three (3) years have elapsed from the date the beds were reclassified to assisted living beds. (7-1-99)T

c. Beds which are added as a result of expansion plans which the Department was made aware of in writing prior to July 1, 1999. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning and/or development. Simply the existence of adequate land and/or space will not constitute having expended significant resources for the pruposes of expansion. A written request with adequate supporting documentation for an exception under this provision must be received by the Department no later than December 31, 1999. In no case will beds added subsequent to July 1, 2003 qualify for the exception to the new bed criteria. (7-1-99)T

d. Beds which are decertified as a requirement of survey and certification due to deficiencies at the facility may be re-certified as existing beds with the approval of the Department. (7-1-99)T

305. TREATMENT OF NEW FACILITIES.
Facilities constructed subsequent to July 1, 1999, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation. During the period of limitation, the facility's rate will be modified each July 1 to reflect the current median rate for skilled care facilities of that type. After the first three (3) full years, the facility will have its rate established at the next July 1 with the existing facilities in accordance with Section 302 of this rule. (7-1-99)T

306. TREATMENT OF A CHANGE IN OWNERSHIP.
New providers resulting from a change in ownership of an existing facility shall receive the previous owner's rate until such time as the new owner has a cost report which qualifies for the rate setting criteria established under these rules. (7-1-99)T

307. DISTRESSED FACILITY.
If the Department determines that a facility is experiencing operational, financial, or patient service problems, the Department may to the extent the provider demonstrates to the satisfaction of the Department that a new rate is appropriate, negotiate a reimbursement rate different than the rate then in effect for that facility. (7-1-99)T

308. INTERIM ADJUSTMENTS TO RATES AS A RESULT OF NEW MANDATES.
Changes in state and federal laws and regulations may (I) result in additional payment for costs, (ii) impact the cost limit calculation of payment rates, or (iii) require restrospective settlement. (7-1-99)T

01. Changes Of More Than Fifty Cents Per Patient Day In Costs. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. (7-1-99)T

a The provider shall report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. (7-1-99)T

b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately. (7-1-99)T

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-99)T

02. Interim Rate Adjustments. For interim rate purposes, the provider may be granted an increase in its prospective rate to cover such cost increases. A cost statement covering a recent period may be required with justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-99)T

03. Future Treatment Of Costs. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed. (7-1-99)T

309. MDS REVIEWS.

The following Minimum Data Set reviews will be conducted: (7-1-99)T

01. Facility Review. Subsequent to the picture date, each facility will be sent a copy of its resident roster (a listing of residents, their RUG classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review. (7-1-99)T

02. Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data. (7-1-99)T

310. SPECIAL RATES.

Section 56-117, Idaho Code, provides authority for the Director to pay facilities a special rate for care given to patients who have long term care needs beyond the normal scope of facility services. These patients must have needs which are not adequately reflected in the rates calculated pursuant to the principles set forth in Section 56-102, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of this section will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. (7-1-99)T

01. Determinations. A determination to approve or not approve a special rate will be made on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request will be for an expected condition that will be on-going for a period of greater than two weeks. (7-1-99)T

02. Application. Until the facility applies for a special rate, patients with such needs will be included in the computation of the facility's rates following the principles described in Section 56-102, Idaho Code. (7-1-99)T

03. Approval. Approved special rates will become effective on the date the application is received, but no earlier than the first day of the month in which the application for a special rate was received. (7-1-99)T

04. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (7-1-99)T

05. Limitation. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services. (7-1-99)T

311. PHASE-IN PROVISIONS.
The rates established pursuant to these rules shall be phased in over a three-year period as follows: (7-1-99)T

01. July 1, 1999 Through June 30, 2000. During this period, providers will continue to be reimbursed under the previous retrospective system; however, the Department will also issue by July 1, 1999 and October 1, 1999, "shadow rates" which will inform facilities what their rate would be under the provisions of these rules. (7-1-99)T

02. July 1, 2000 Through December 31, 2000. Rates calculated under the provisions of these rules will be compared to the rates that were available to the same facility as of June 30, 1999. Facilities which would experience decreases in their rate of one dollar ($1) or less per resident day will receive the rate established under the provisions of these rules with no phase-in. Facilities which would experience decreases in their rate of greater than one dollar ($1) per resident day will have the decrease in their rate limited to the greater of one dollar ($1) per resident day or twenty-five percent (25%) of the decrease. Facilities which would experience increases in their reimbursement rate will receive the increased rate. (7-1-99)T

03. January 1, 2001 Through June 30, 2001. Rates calculated under the provisions of these rules will be compared to the rates that were available to the same facility as of June 30, 1999. Facilities which would experience decreases in their rate of two dollars ($2) or less per resident day will receive the rate established under the provisions of these rules with no phase-in. Facilities which would experience decreases in their rate of greater than two dollars ($2) per resident day will have the decrease in their rate limited to the greater of two dollars ($2) per resident day or fifty percent (50%) of the decrease. Facilities which would experience increases in their reimbursement rate will receive the increased rate. (7-1-99)T

04. July 1, 2001. Beginning with July 1, 2001, the rates established under the provisions of these rules will be fully implemented with no phase-in. (7-1-99)T

312. (RESERVED)

313. DISPUTES.

01. Administrative Review Requirement. If any facility wishes to contest the way in which a rule or contract provision relating to the prospective, cost-related reimbursement system was applied to such facility by the Director, it shall first pursue the administrative review process set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 300, et seq., and Section 301, "Rules Governing Contested Cases and Declaratory Rulings". (12-31-91)

02. Legal Challenge. The administrative review process need not be exhausted if a facility wishes to challenge the legal validity of a statute, rule, or contract provision. (12-31-91)

314. DENIAL, SUSPENSION, REVOCATION OF LICENSE OR PROVISIONAL LICENSE -- PENALTY.
The Director is authorized to deny, suspend, or revoke a license or provisional license or, in lieu thereof or in addition thereto, assess monetary penalties of a civil nature not to exceed one thousand dollars ($1000) per violation

in any case in which it finds that the facility, or any partner, officer, director, owner of five percent (5%) or more of the assets of the facility, or managing employee: (12-31-91)

01. Failed Or Refused To Comply. Failed or refused to comply with the requirements of Sections 56- 101 through 56-135, Idaho Code, or the rules established hereunder; or (1-1-82)

02. False Statements. Has knowingly or with reason to know made a false statement of a material fact in any record required by this chapter; or (1-1-82)

03. Refused To Allow Representative. Refused to allow representatives or agents of the Director to inspect all books, records, and files required to be maintained by the provisions of this chapter or to inspect any portion of the facility's premises; or (1-1-82)

04. Wilfully Prevented, Interfered With, Or Attempted To Impede Work. Wilfully prevented, interfered with, or attempted to impede in any way the work of any duly authorized representative of the Director and the lawful enforcement of any provision of this chapter; or (1-1-82)

05. Preservation Of Evidence. Wilfully prevented or interfered with any representative of the Director in the preservation of evidence of any violation of any of the provisions of this chapter. (12-31-91)

315. -- 349. (RESERVED).

350. AUDITS.
The objectives of an audit are: (1-16-80)

01. Accuracy Of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (1-16-80)

02. Reliability Of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results to the provider's operations. (1-16-80)

03. Economy And Efficiency. To determine if Title XIX recipients have received the required care on a basis of economy and efficiency. (1-16-80)

04. Application Of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (1-16-80)

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding his fiduciary responsibilities for patients, funds and property. (1-16-80)

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (1-16-80)

07. Compliance. To provide recommendations which will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program recipients. (1-16-80)

08. Final Settlement. To effect final settlement when required by Sections 250 through 350 of this rule. (7-1-99)T

351. PRINCIPLE.
All financial reports will be subject to audit in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.12, "Rules Governing Audits of Providers". (4-28-89)

352. APPLICATION.

01. **Annual Audits**. Normally, all annual statements will be audited within the following year. (1-16-80)

02. **Limited Scope Audit**. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (1-16-80)

03. **Additional Audits**. In addition, audits may be required where: (1-16-80)

a. A significant change of ownership occurs. (1-16-80)

b. A change of management occurs. (1-16-80)

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (1-16-80)

04. **Audit Appointment**. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (1-16-80)

353. STANDARDS AND REQUIREMENTS.

01. **Review Of New Provider Fiscal Records**. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (1-16-80)

02. **Requirements**. Section 2404.3 of the August, 1973 revision of the Providers Reimbursement Manual (PRM) states: "Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary." (7-1-99)T

03. **Examination Of Records**. Examination of records and documents may include, but not be limited to: (1-16-80)

a. Corporate charters or other documents of ownership including those of a parent or related companies. (1-16-80)

b. Minutes and memos of the governing body including committees and its agents. (1-16-80)

c. All contracts. (1-16-80)

d. Tax returns and records, including workpapers and other supporting documentation. (1-16-80)

e. All insurance contracts and policies including riders and attachments. (1-16-80)

f. Leases. (1-16-80)

g. Fixed asset records (see audit section - Capitalization of Assets). (1-16-80)

h. Schedules of patient charges. (1-16-80)

i. Notes, bonds and other evidences of liability. (1-16-80)

j. Capital expenditure records. (1-16-80)

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (1-16-80)

l. Evidence of litigations the facility and its owners are involved in. (1-16-80)

m. Documents of ownership including attachments which describe the property. (1-16-80)

n. All invoices, statements and claims. (1-16-80)

o. "Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit workpapers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request." (PRM, paragraph 2404.4(Q) of the Providers Reimbursement Manual) (7-1-99)T

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (1-16-80)

q. All patient records, including trust funds and property. (1-16-80)

r. Time studies and other cost determining information. (1-16-80)

s. All other sources of information needed to form an audit opinion. (1-16-80)

04. Adequate Documentation. (1-16-80)

a. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited (PRM, Section 2304). (7-1-99)T

b. Expenses. Adequate documentation would normally include: an invoice, or a statement with invoices attached which support the statement. All invoices should meet the following standards: (1-16-80)

i. Date of service or sale; (1-16-80)

ii. Terms and discounts; (1-16-80)

iii. Quantity; (1-16-80)

iv. Price; (1-16-80)

v. Vendor name and address; (1-16-80)

vi. Delivery address if applicable; (1-16-80)

vii. Contract or agreement references; and (1-16-80)

viii. Description, including quantity, sizes, specifications brand name, services performed, etc.; (1-16-80)

c. Capitalization of Assets. Major movable equipment shall be capitalized. Minor movable equipment shall not be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset (PRM, Section 108.1). This rule shall apply except as to the provisions of Section 106 of PRM for small tools, etc. (7-1-99)T

i. Completed depreciation records must meet the following criteria for each asset: (1-16-80)

(1) Description of the asset including serial number, make, model, accessories, and location. (1-16-80)

(2) Cost basis should be supported by invoices for purchase, installation, etc. (1-16-80)

(3) Estimated useful life. (1-16-80)

(4) Depreciation method such as straight line, double declining balance, etc. (1-16-80)

(5) Salvage value. (1-16-80)

(6) Method of recording depreciation on a basis consistent with accounting policies. (1-16-80)

(7) Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (1-16-80)

(8) Reported depreciation expense for the year and accumulated depreciation shall tie to the asset ledger. (1-16-80)

ii. Depreciation Methods and Lives. (12-31-91)

(1) Methods. Straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (4-28-89)

(2) Depreciable Lives. The life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 1993 revised edition Guidelines Lives, which is hereby incorporated by reference into these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (7-1-99)T

iii. Lease Purchase Agreements. Lease purchase agreements may generally be recognized by the following characteristics: (1-16-80)

(1) Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (4-28-89)

(2) Intent to create security interest; (1-16-80)

(3) Lessee may acquire title through exercise of purchase option which requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (1-16-80)

(4) Noncancellable or cancellable only upon occurrence of a remote contingency; and (1-16-80)

(5) Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (1-16-80)

iv. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (12-31-91)

d. Personnel. Complete personnel records normally contain the following: (1-16-80)

i. Application for employment. (1-16-80)

ii W-4 Form. (1-16-80)

iii. Authorization for other deductions such as insurance, credit union, etc. (1-16-80)

iv. Routine evaluations. (1-16-80)

v. Pay raise authorization. (1-16-80)

vi. Statement of understanding of policies, procedures, etc. (1-16-80)

vii. Fidelity bond application (where applicable). (1-16-80)

05. Internal Control. (1-16-80)

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (1-16-80)

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (1-16-80)

ii. Promoting accuracy and reliability in financial records. (1-16-80)

iii. Encouraging and measuring compliance with company policy and legal requirements. (1-16-80)

iv. Determining the degree of efficiency related to various aspects of operations. (1-16-80)

b. An adequate system of internal control over cash disbursements would normally include: (1-16-80)

i. Payment on invoices only, or statements supported by invoices. (1-16-80)

ii. Authorization for purchase such as a purchase order. (1-16-80)

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (1-16-80)

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (1-16-80)

v. Check of invoice accuracy. (1-16-80)

vi. Approval policy for invoices. (1-16-80)

vii. Method of invoice cancellation to prevent duplicating payment. (1-16-80)

viii. Adequate separation of duties between ordering, recording, and paying. (1-16-80)

ix. System separation of duties between ordering, recording, and paying. (1-16-80)

x. Signature policy. (1-16-80)

xi. Prenumbered checks. (1-16-80)

xii. Statement of policy regarding cash or check expenditures. (1-16-80)

xiii. Adequate internal control over the recording of transactions in the books of record. (1-16-80)

xiv. An imprest system for petty cash. (1-16-80)

06. Accounting Practices. Sound accounting practices normally include the following: (1-16-80)

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (1-16-80)

b. Chart of accounts. (1-16-80)

c. A budget or operating plan. (1-16-80)

354. PATIENT FUNDS.
The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (1-16-80)

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (1-16-80)

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (1-16-80)

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (1-16-80)

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or his agent in writing. (9-1-85)

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (1-16-80)

03. Fund Management. Proper management of such funds would include the following as minimum: (1-16-80)

a. Savings accounts, maintained separately from facility funds. (1-16-80)

b. An accurate system of supporting receipts and disbursements to patients. (1-16-80)

c. Written authorization for all deductions. (1-16-80)

d. Signature verification. (1-16-80)

e. Deposit of all receipts of the same day as received. (1-16-80)

f. Minimal funds kept in the facility. (1-16-80)

g. As a minimum these funds must be kept locked at all times. (1-16-80)

h. Statement of policy regarding patient's funds and property. (1-16-80)

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (1-16-80)

j. System of periodic review and correction of policies and financial records of patient property and funds. (1-16-80)

355. DRUGS.

The rules governing payment for prescription drugs to outpatients are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, Sections 126 through Subsection 090.01, "Rules Governing Medical Assistance". (12-31-91)

01. Nonlegend Drugs. (7-1-93)

a. For providers which have no pharmacy on the premises, reimbursement will be available for nonlegend drugs subject to a test of reasonableness related to the market place and must not exceed the pharmacist's charges to private pay patients. This means that charges to the patient may not exceed the billing to the provider including, but not limited to, adjustments by discounts or terms. (9-1-85)

b. For providers who have a pharmacy on the premises, reimbursement will be available for nonlegend drugs at cost plus a dispensing fee established by the Division of Medicaid. (7-1-99)T

02. Record-Keeping Requirements. According to requirements in the Providers Reimbursement Manual PRM, Section 2104, the provider, as part of its financial record keeping responsibility under the program, must have on supplier invoices all needed cost verification information including name brand, quantity, form and strength of the drugs supplied and the provider's actual cost. In the absence of such information and in accordance with Section 1815 of the Social Security Act and Section 405.453 of the regulations, the Department must deny charges for unlabeled drugs because of inadequate records. Any cost reductions received on drug purchases including, but not limited to, discounts (cash, trade, purchase and quantity), or rebates, must also be clearly reflected on the individual invoices or related documentation. (7-1-99)T

356. ACCOUNTING TREATMENT.

Generally accepted accounting principles, concepts, and definitions shall be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be that one which most clearly attains program objectives. (1-16-80)

01. Final Payment. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. In addition, an efficiency incentive will be allowed to low cost providers in accordance with the provisions of Section 255. (12-31-91)

02. Overpayments. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. (1-16-80)

03. Other Actions. Generally overpayment shall result in two (2) circumstances: (1-16-80)

a. If the cost report is not filed the sum of the following shall be due: (1-16-80)

i. All payments included in the period covered by the missing report(s). (1-16-80)

ii. All subsequent payments. (1-16-80)

b. Excessive reimbursement or noncovered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction shall be designated to effect at least one of the following: (1-16-80)

i. Discontinuance of overpayments (on an interim basis). (1-16-80)

ii. Recovery of overpayments. (1-16-80)

357. -- 399. (RESERVED).

400. PROVIDER RIGHTS AND OBLIGATIONS.

01. Provider Rights. (7-1-93)

a. Appeal Procedure. Provisions for appealing interim rates, program determinations, or final audit reports are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Sections 330, et seq., and Section 301, "Rules Governing Contested Cases and Declaratory Rulings". (12-31-91)

b. Clarification. Providers shall have the right to receive information, clarification, etc., about policies, recommendations or criteria set forth in the Title XIX guidelines. (1-16-80)

c. Clarification. Providers or their agents may write, call or appear in person to receive clarification regarding any policy, procedure or requirement of the program. (1-16-80)

i. Telephone calls are acceptable for the conveyance of general information but present confidentiality and other problems. Therefore, their use is limited. (1-16-80)

ii. Written requests are preferred for special requests or clarification. In some cases written requests may be required. (1-16-80)

iii. Personal inquiries are always welcome. An atmosphere of cooperation between providers and the Department is encourages. Such a relationship facilitates the type of information exchange and responsibility that the Department has assumed as intermediary in the program. In order to reasonably ensure the availability of staff for appointments, it would be well to confirm an appointment prior to arrival. (1-16-80)

d. Consultant Services. All providers may use the Department as a consultant to the extent that such activities relate to patient care. (1-16-80)

e. Withdrawal. All providers have the right to withdraw from program participation as specified in the state of Idaho, Title XIX Medicaid Provider Agreement. (1-16-80)

02. Provider Obligations. Providers and their agents shall be obligated to operate in a manner consistent with overall economy and efficiency. (1-16-80)

a. Provider Agreement Provisions. Providers may not enter into any agreement or transaction which violates their provider agreement or position of trust regarding program beneficiaries. (1-16-80)

b. Notification. All providers will be required to notify the intermediary of significant changes in ownership, management, policies, or procedures. This shall also apply to any entity related to the provider. (1-16-80)

c. Providing Information. Providers shall be obligated to provide all requested information, documents, etc., to Departmental auditors. Failure to comply may result in disallowances. (1-16-80)

d. Changes in Fiscal Years. Providers are required to report a change in fiscal year. (1-16-80)

e. Reporting. Providers are required to notify the Department when there is a change in interim rates, entry into or withdrawal from the Title XVIII Medicare Program. (1-16-80)

401. (RESERVED).

402. IDAHO OWNER-ADMINISTRATIVE COMPENSATION.
Allowable compensation to owners and persons related to owners who provide any administrative services shall be limited based on the schedule in this Section. (7-1-97)

01. Allowable Owner Administrative Compensation. The following schedule shall be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 1996.

Licensed Bed Range	Upper limit
51 - 100	67,300
101 - 150	74,025
151 - 250	100,525
251 - up	144,300

(7-1-97)

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section shall be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by Data Resources Incorporated, its successor organization or, if unavailable, another nationally recognized forecasting firm. (7-1-97)

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 402.01. Allowable compensation will be determined as follows: (7-1-97)

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services shall be counted, regardless of whether they are in the same facility. (7-1-97)

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. (7-1-97)

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and shall be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service shall be documented. In no event shall the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 402.01 of these rules. (7-1-97)

04. Compensation For Persons Related To An Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner. (7-1-97)

05. When An Owner Provides Services To More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners. (7-1-97)

06. More Than One Owner Or Related Party May Receive Compensation For Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured shall be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and shall not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, shall not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). (7-1-97)

403. -- 404. (RESERVED).

405. ANCILLIARY AND ROUTINE NURSING SUPPLIES.

01. Ancillary Supplies.

Ancillary Supplies
Artificial Limbs
Canes
Laboratory Tests
Legend Drugs and Insulin paid to facilities on a patient and prescription specific basis
Radiology
X-ray

(7-1-93)

02. Routine Supplies.

Routine Supplies
A & D Ointment
ABD Pad
Ace Bandages
Acquamatic K Pads
Air Mattress
Alcohol Applicators
Arm Slings
Asepto Syringes
Autoclave Sheets
Baby Powder
Band Aid Spots
Band Aids
Bandages/Elastic
Bandages/Sterile
Basins
Bed Frame Equipment
Bed Pans
Bedside Tissues
Benzoin Aerosol
Bibs
Bottles/Specimen
Braces
Butterfly Closures
Cannula/Nasal
Catheter Clamp
Catheter Plug
Catheter Tray
Catheters, any size
Catheters/Irrigation
Clinitest
Clysis Set

Coloplast
Cotton Balls
Crutches
Decubitus Ulcer Pads
Defecation Pads
Denture Cup
Deodorant
Dermassage
Disposable Leg Bag
Disposable Underpads
Donut Pad
Douche Bags
Drainage Bags
Drainage Sets
Drainage Tubing
Dressing/Sterile
Dressing Tray
Drugs Nonlegend
Enema Cans/Disposable
Enema/Fleets
Enema/Fleets in Oil
Female Urinal
Finger Cots
Flex Straws
Flotation Mattress
Foot Cradle
Gastric Feeding Tube
Gloves/Nonsterile
Gloves/Sterile
Gowns
Hand Feeding
Harris Flush Tube
Heat Cradle
Heating Pad
Heel Protectors
Hexol
Hot Pack Machine
Ice Bag
Identification Bands
Incontinency Care
Invalid Ring
IPPB Machine
Irrigation Bulb
Irrigation Set

Irrigation Solution
Irrigation Tray
IV Set
Jelly/Lubricating
Killet Ampules
Kleenex
Kling bandages/Sterile
KY Jelly
Levine Tube
Linen
Lotion
Maalox
Male Urinal
Massages
Medical Social Services
Medicine Cups
Medicine Dropper
Merthiolate Spray
Milk of Magnesia
Mineral Oil
Mouthwashes
Nasal Cannula
Nasal Catheter
Nasal Gastric Tube
Nasal Tube
Needles
Nonallergic Tape (paper tape)
Nursing Services
Occupational Therapy
Ointment/Skin Nonprescription
Overhead Trapese
Oxygen
Oxygen Equipment-IPPB
Oxygen Mask/Disposable
Oxygen/Nondisposable
Peroxide
Personal Laundry (except for dry cleaning and special laundry)
Pitcher
Physical Therapy*
Plastic Bib
Pumps*

Rectal Tube
Restraints
Room and Board
Sand Bags
Scalpel
Sheep Skin
Special Diets
Specimen Cup
Speech Therapy
Sponges/Sterile
Sterile Pads
Stomach Tube
Suction Machines
Suppositories
Surgical Dressings
Surgical Pads
Surgical Tape/Nonallergic
Suture Set Suture Tray
Swabs/Lemon & Glycerin
Tape (Lab-Testing)
Tape/Autoclave
Testing Sets/Refills
Thermometers
Tincture of Benzoin
Tongue Blades
Tracheostomy Sponges
Tray Service
Tubing/IV
Tubing/Blood
Tubing/Drainage
Urinals
Urinary Drainage Tube Underpads (if more than occasional use)
Urological Solutions
Vaseline
Walkers
Water Pitchers
Wheel Chairs
Water for Injection

*Subject to Department policy

(1-1-82)

406. (RESERVED).

407. COSTS FOR THE COMPLETION OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPs) IN NURSING FACILITIES (NFs) EXCLUDING ICF/MR FACILITIES AND FOR COMPLYING WITH CERTAIN OTHER REQUIREMENTS.

Provisions of federal law require the state to give special treatment to costs related to the completion of training and competency evaluation of nurse aides and to increase rates related to other new requirements. Treatment will be as follows: (9-28-90)

01. Cost Reimbursement. Effective for cost reports filed and for payments made after April 1, 1990, such NATCEP costs shall be outside the content of nursing facility care and shall be reimbursed separately as an ancillary cost. (9-28-90)

02. Costs Subject To Audit. Such NATCEP costs shall remain subject to audit, shall be reported separate from other costs, shall be reported by all NFs including those which are hospital based and will not be included in the percentile cap. (9-28-90)

03. Payment Adjustments. Beginning April 1, 1990, interim NF payments will be adjusted to exclude NATCEP costs from the content of NF care, separate payments covering such costs will be made, and payment rates will be revised to cover certain other costs. (9-28-90)

a. NATCEP's costs are not part of the content of nursing home care, are to be reported separately on cost reports by all NF's and are reimbursed separate from NF interim rates. Such costs incurred from July 1, 1988 through September 30, 1990 will be reimbursed at one hundred percent (100%) of reasonable cost; NATCEP costs incurred thereafter will be separately reimbursed based on the Medicaid share of reasonable costs. (9-28-90)

b. Reimbursement for new costs, other than NATCEP related costs, which result from Public Law 100-203 (OBRA 1987) will be incorporated in interim NF payments effective October 1, 1990 for those providers who document such costs by October 1, 1990. Acceptable documentation will include estimated wages and benefits for new employees or net increases in scheduled working hours for specific current employees in order to comply with new requirements under OBRA 1987. The Department will provide forms for listing items related to the added costs including: (9-28-90)

i. New employees; (9-28-90)

ii. Related new responsibilities; (9-28-90)

iii. Products and services added; (9-28-90)

iv. Products and services no longer required; (9-28-90)

v. Added hours required; (9-28-90)

vi. Wage rates and other costs related to the net added products and services; and (9-28-90)

vii. The benefits rate for the facility. (9-28-90)

c. Interim rate increases will be based on total estimated added annual costs divided by the number of annual patient days used in determining the remainder of the interim rate. These rate increases are subject to reevaluation and revision based on actual costs. Interim payments are intended to approximate as closely as possible the final settlement amount. The final settlement for increases related to new costs resulting from OBRAs will be no more or less than audited actual cost. There will be no percentile cap or efficiency increment applied to these new costs. (9-28-90)

d. A rate change for new costs related to OBRA 1987 will not count toward the limit of two (2) adjustments per year as addressed in Subsection 303.03. (12-31-91)

408. QUALITY INCENTIVES.

Nursing facility providers that are recognized for providing high quality care, based on determinations by the agency of the Department that inspects and certifies such facilities for participation in the Medicaid program, shall be eligible for incentive payments. The amount of such payments and the basis therefore will be determined by the Director and will be paid in addition to any other payments for which the facility is eligible under other provisions of this chapter, including provisions related to limitations related to customary charges. However, such payments will be subject to available State and federal funds and will be postponed or omitted in the event that such payments along with other payments made to Nursing Facilities under this chapter would, in aggregate, exceed the estimated payments that would be made utilizing Medicare principles of cost reimbursement. (7-1-97)

409. -- 448. (RESERVED).

APPENDICES

The following appendices are to clarify provisions specifically referred to in the Idaho State plan. Any other provisions contained in the appendices are not intended to be a part of the State Plan. Such other provisions are to assure the reader of the context of those provisions that directly relate to the State Plan in order to avoid errors in understanding those specific provisions.

Appendix A: Idaho State Code extractions referred to in the State Plan

Appendix B: Facility Definitions from Idaho Code

Appendix C: Parts of the Medical Assistance Rules

Appendix D: Audit rules

Appendix E: Section 250. through 256. of Attachment 4.19-D approved under TN96-09 and applicable to nursing facility reimbursement through June 30, 1999

Appendix F: Sections of Idaho Code effective July 1, 1999 and Assurance of Public Notice

SECTIONS 250. THROUGH 256. OF ATTACHMENT 4.19-D APPROVED UNDER TN 96-09 AND APPLICABLE TO NURSING FACILITY REIMBURSEMENT THROUGH JUNE 30, 1999

Provisions in this appendix are only applicable to the Idaho State Plan to the extent that such provisions are directly related to references in the plan to these provisions. in the event of any conflict, difference of definition, ambiguity, discrepancy, or dispute, arising from provisions in this appendix, the provisions of this appendix are subordinate to state plan provisions not in this appendix as determined by the Department. Furthermore, any references to laws, rules, or documents which are exclusive to this appendix (which are not in Attachment 4.19-D of the State Plan) are to be deemed extraneous to the plan.

IDAPA 16
TITLE 03
Chapter 10
250. through 256.

250. PROSPECTIVE CAPS.

Sections 250 through 256 of these rules, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56- 135, Idaho Code. (10-1-96)T

251. PRINCIPLE.

Providers of nursing home services will be paid at the allowed amount determined in accordance with Section 56-101 to 56-135, Idaho Code. Total payment will be made up of the total of the following components: (1-1-82)

01. Property and Utility Costs. All allowable property and utility costs; (9-15-84)

02. Nonproperty, Nonutility Costs. Nonproperty nonutility costs as determined in accordance with the above mentioned Sections of the Idaho Code. (9-15-84)

03. Efficiency Increment. An efficiency increment determined in accordance with the above mentioned Sections of the Idaho Code. (1-1-82)

04. Exempt Costs. Other allowable costs exempt from the percentile cap under Sections 56-110(b) and 56-117, Idaho Code, as specified in Subsection 254.08 and 254.09. (12-31-91)

252. PROPERTY AND UTILITY COSTS.

The allowability of each of these cost items will be determined in accordance with other provisions of this chapter, or the HIM-15 in those cases where this the rules of this chapter are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (10-1-96)T

01. Depreciation. All allowable depreciation expense. (1-1-82)

02. Interest. All allowable interest expense relating to financing building and equipment purchases. Interest on working capital loans will be included as administrative costs. (1-1-82)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs. (1-1-82)

04. Lease Payments. All allowable lease or rental payments. (1-1-82)

05. Property Taxes. All allowable property taxes. (1-1-82)

06. Utility Costs. All allowable expenses for heat, electricity, water and sewer. (9-15-84)

253. (RESERVED).

254. COSTS SUBJECT TO A CAP FOR NURSING FACILITIES.
Final reimbursement of these costs will be limited to the amount allowed as determined in accordance with Sections 56-101 through 56-135, Idaho Code. This Section defines items and procedures to be followed in determining this limit. Specifically, this Section provides the procedures for: (10-1-96)T

01. Determining Costs. Extracting cost data from historical cost reports, cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the standard deviation of the range of costs and the percentile cap. (1-1-82)

02. Allowable Costs. Allowable costs to be included in this Section, as determined in accordance with this chapter or HIM-15, will be divided by the total patient days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid patients are not included on the total submitted costs for those services, the provider must determine the amount of those costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for the purpose of determining the percentile cap and for computing final reimbursement. (12-31-91)

03. Cost Data for Hospital Based Facilities. Cost data to be used to determine the percentile cap for facilities in the hospital facilities based class shall be taken from each provider's most recent twelve (12) month audit report finalized by the Department prior to ninety (90) days before the beginning of the period for which the percentile cap is being determined. (9-28-90)

04. Cost Data for Freestanding Nursing Facilities. Cost data to be used to determine the percentile cap for facilities in the Freestanding Nursing Facilities class shall be taken from each provider's most recent fiscal period closing cost report received by the Department prior to one hundred and twenty (120) days before the beginning of the period for which the percentile cap is being determined. For cost reports covering a period of less than twelve (12) months the reports will be annualized for purposes of cost projections of Subsection 254.10 by extending the reporting period used to one (1) year from the beginning of the cost reporting period. (10-1-96)T

05. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the table in Subsection 254.07. (12-31-91)

a. Cost Forecasting Market Basket:

Cost Category and Description	Forecaster
Payroll Expense - all wages and salaries excluding benefits	Average hourly earnings in nursing homes and personal care facilities homes
Employee Benefits	Skilled nursing facility employee benefits
Food – Wholesale Price Index	Processed foods and feeds component of the producers price index
Supplies – Include nursing, dietary, laundry, housekeeping and maintenance supplies	All Item Consumer Price Index
Other Business Services - include dues, subscriptions, accounting and legal services, employee recruitment, telephone, office supplies and home office costs.	Service component of the Consumer Price Index
Fuel Oil and Coal	Fuel oil component of the Consumer Price Index
Electricity	Electricity component of the Consumer Price Index
Natural Gas	Utility gas component of the Consumer Price Index
Miscellaneous	All Item Consumer Price Index

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by a successor organization or an organization providing such indices used by the federal government to comply with law or regulation related to forecasting health care costs will be used.

06. Special Rates. Section 56-117, Idaho Code, provides for authority to the Director to pay facilities at special rates for care given to patients who have long term care needs beyond the normal scope of facility services. Patients with such needs who are otherwise unable to be placed in a nursing facility may include, but are not limited to, ventilator assisted patients, certain pediatric patients, certain comatose patients, and certain patients requiring nasogastric or intravenous feeding devices. In the event that the Director exercises this authority: (12-28-89)

a. A determination to approve or not approve a special rate will be made on a patient by patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid resource. (12-28-89)

b. A rate for each approved Medicaid patient will be set by the Department for extra costs the patient is expected to incur in excess of the cost of normal facility services. (12-28-89)

c. Costs equivalent to payments at the special rate will be removed from the category of costs subject to the percentile cap, will be reported separately, and will be fully reimbursed. (12-28-89)

d. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services. A provider's charges to non-Medicaid patients for similar needs beyond the normal scope of nursing facility services will be the maximum reimbursable amount related to the special rate. If the provider has no other patients who receive such services in the reporting period, the provider's published charges applicable to non-Medicaid patients for such needs will be the maximum reimbursable amount for the special rate. (12-28-89)

07. Costs Excluded From The Percentile Cap. For cost reports filed on or after July 1, 1989, identifiable increases in costs with an expected impact of two cents ($.02) or more per patient day otherwise subject to the percentile cap incurred by facilities in the ICF/SNF Freestanding class as a result of changes in state or federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the percentile cap. (12-28-89)

a. A separate schedule or notations on the cost report are to be included so these excluded costs can be identified and so reported costs can be reconciled to the provider's general ledger. (12-28-89)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. (12-28-89)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department provides otherwise. (12-28-89)

d. For interim rate purposes the provider may be granted an increase in interim rates to cover such cost increases as allowed for in Section 303. A cost statement covering a recent period should be submitted with the justification for the increased costs. (12-31-91)

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at a time of its choosing, include all of the previously excluded costs related to those increases with costs subject to the percentile cap when setting rates. If a percentile cap is set with these particular costs included in the percentile cap category, providers subject to that percentile cap will not have these costs excluded from the percentile cap for interim rate or final settlement purposes. The intent of this provision is for costs to be exempt from the percentile cap until these costs are able to be fully and equitably incorporated in the data base used to set the percentile cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. (12-28-89)

f. When cost increases are to be excluded from the percentile cap and the effect of these cost increases would also be incorporated in the inflation indexes used to set the percentile cap, the cost indexes will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the percentile cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. (12-28-89)

08. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the cost reporting period from which they were derived to the midpoint of the period for which the reimbursement and the limitation of these costs is being calculated. Procedures for inflating these costs are as follows: (1-1-82)

a. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the period from which the per diem costs were derived. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem

costs for each cost category from the midpoint of the period from which the costs were derived to the end of that period. (1-1-82)

b. The percentage change for each cost category in the market basket will be computed for the period beginning at the end of the period from which the per diem costs were derived and ending at the beginning of the period for which the reimbursement and the limitation of these costs is being calculated. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 254.10.a. from the end of the period from which they were derived to the beginning of the period for which the reimbursement and the limitation is being determined. (12-31-91)

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the period for which the reimbursement and the limitation is being computed. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 254.10.b. from the beginning to the midpoint of the period for which the reimbursement and the limitation is being computed. (12-31-91)

09. Cost Ranking. Projected per diem costs as determined by Subsection 254.10 and subject to the percentile cap will be ranked from highest to lowest within each class of providers. Costs for providers will be grouped in classes according to the type of provider with the classes being Freestanding Nursing Facilities, Hospital Based Facilities, and ICF/MR. (12-31-91)

a. The standard deviation of the range will be computed based on the available data points being considered the total population of data points. (1-1-82)

b. The standard deviation figure will then be used to determine the percentile cap in accordance with the Idaho Code as follows:

If Two Times the Standard Deviation is	Then the Percentile Cap Will be
$2.99 or less	100%ile
$3.00 to $5.99	90%ile
$6.00 to $11.99	80%ile
$12.00 or greater	75%ile

(1-1-82)

c. The percentile cap will be computed based on the assumption that the range of costs is a statistically normal distribution unless the cap is to be at the one hundred (100) percentile. In that case, the highest cost in the range will become the percentile cap. (1-1-82)

d. The percentile cap for each facility's fiscal year following January 1, 1982, will be computed prior to the beginning of that fiscal year in accordance with the Idaho Code. For those facilities with a fiscal year ending on a date other than December 31, the first percentile cap will be computed for the period beginning January 1, 1981, and ending on their fiscal year end date. (1-1-82)

e. The percentile cap will be determined and set for each facility's upcoming fiscal year prior to that year and it will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical type errors, these errors will be corrected and the percentile cap adjusted to what it would compute to be using the corrected figures. (1-1-82)

f. Reimbursement of costs in this cost center will be limited to the percentile cap unless the provider can demonstrate to the Department of Health and Welfare that his facility was operated efficiently during the cost reporting period and that the costs incurred in excess of the percentile cap were beyond his control. In such case, costs in excess of the cap will be allowed to the extent that they are justified by this process. This is intended to allow the Department to determine if a facility was operated efficiently, in whole or in part, based on a demonstration of efficiency by the facility or another party. The Department can grant an exception to all or part of a percentile cap disallowance to the extent that there is a reasonable and prudent reason for the higher costs. (1-1-82)

g. Facilities which for the first time offer patient care services in the hospital-based facilities class on or after April 1, 1985, shall be subject to the same limitation on nonproperty nonutility reimbursement as is applied to the freestanding nursing facilities class with the same fiscal year as the hospital-based provider. The efficiency increment for such facilities shall be computed based on the fraction applicable to the freestanding nursing facilities class. Cost reports for such facilities shall be included in the hospital-based facilities class. (9-28-90)

255. EFFICIENCY INCREMENT.

A nursing facility efficiency increment will be included as a component of the total reimbursement if the allowable per diem costs incurred by the nursing facility provider for those cost categories subject to the percentile cap addressed in Section 254, are less than percentile cap for the class in which the facility belongs. (10-1-96)T

01. Computing Efficiency Increment. The efficiency increment will be computed by subtracting the actual allowable per diem costs incurred by the provider from the applicable percentile cap and multiplying the resultant figure by the fraction applicable to the cost center according to the following table: (1-1-82)

EFFICIENCY INCREMENT	
Percentile Cap Applicable to The Class of Facilities	Fraction to be Used in Determining the Efficiency Increment
100%ile	One-half (1/2)
90%ile	One-third (1/3)
80%ile	One-fourth (1/4)
75%ile	One-sixth (1/6)

02. Allowable Increment. The allowable increment cannot exceed one dollar and fifty cents ($1.50) per Medicaid patient-day. (1-1-82)

03. Determining Reimbursement. Total reimbursement determined by adding amounts determined allowable in accordance with Sections 252, 253, 254, and 255, shall not exceed the

provider's usual and customary charges for these services as computed in accordance with this chapter and HIM-15. In computing patient days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the patient is making payment for holding a bed in the facility, the patient will not be considered to be discharged and thus those days will be counted in the total (treatment of bed hold days or leave of absence days are as addressed in Appendix C). (12-31-91)

256. DEFINITIONS. (7-1-93)

01. Lower of Cost or Charges. In addition to 42 CFR Part 447, the Title XIX Medical Assistance Manual (MSA) PRG 1, Part 6-170-20B states that on cost related basis of reimbursement "... the limit on payments for extended care facilities (ECF's) under Title XVIII shall not exceed ...". These limits are determined on an individual facility basis for comparable service. Supplement 5 of the 1972 amendments to the Providers Reimbursement Manual (SSA HIM-15) states "regulations based on the 1972 amendments (as revised by section 16 of P.L. 93-233) state that for services rendered in cost reporting periods beginning after December 31, 1973, payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public shall be the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge shall be reimbursed fair compensation which is the same as reasonable cost." (1-16-80)

02. Customary Charges. Customary charges are the regular rates for various services which are recorded for Medicare beneficiaries and charges to patients liable for such charges. Those charges are to be adjusted downward, however, where the provider does not impose such charges on most patients liable for payment on a charge basis or, fails to make reasonable collection efforts, the reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt (see Chapter 3, Sections 310 and 312, HIM-15). (1-16-80)

03. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (1-16-80)

04. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. The result of this is that the Title XIX rate may not exceed the Title XVIII rate, less ancillary charges or charges to third parties (i.e. general public) for comparable services. (1-16-80)

a. Assuming that the Title XVIII Part A rate is ten dollars ($10) per patient day (not including ancillaries), customary charges are fifteen dollars ($15) per patient day. (12-31-91)

b. In this case the customary charges are in excess of the potential rate so they are not a limiting factor. However, the Title XVIII Part A rate is less for equivalent services. Therefore, the interim reimbursement rate will be at the ICF/SNF rate of ten dollars ($10) per patient day. (12-31-91)

Idaho State Code extractions including references in Idaho State Plan

Provisions in this supplement are only applicable to the Idaho State Plan to the extent that such provisions are directly related to references in the plan to these provisions. In the event of any conflict, difference of definition, ambiguity, discrepancy, or dispute arising from provisions in this appendix, the provisions of this appendix are subordinate to state plan provisions not in this supplement as determined by the Department. Furthermore, any references to laws, rules, or documents which are exclusive to this supplement (which are not in Attachment 4.19-D of the State Plan) are to be deemed extraneous to the plan.

TITLE 56
PUBLIC ASSISTANCE AND WELFARE
CHAPTER 1
PAYMENT FOR SKILLED AND
INTERMEDIATE SERVICES

56-101. DEFINITIONS. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter and shall have the following meanings

(1) "Appraisal" means the method of determining the value of the property as determined by an appraisal conducted by a member of the appraisal institute (MAI), or successor organization. The appraisal must specifically identify the values of land, building, equipment, and goodwill.

(2) "Assets" means economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles.

(3) "Bed-weighted median" is determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per them costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median.

(4) "Case mix index" is a numeric score assigned to each facility resident, based on the resident's physical and mental condition, which projects the amount of relative resources needed to provide care to the resident.

(5) "Depreciation" means the systematic distribution of the cost or other tangible assets, less salvage, over the estimated useful life of the assets.

(6) "Direct care costs" consists of the following costs directly assigned to the nursing facility or allocated to the nursing facility through medicare cost finding principles

(a) Direct nursing salaries which include the salaries of registered nurses, licensed professional nurses, certified nurse's aides, and unit clerks; and

(b) Routine nursing supplies; and

(c) Nursing administration; and

(d) Direct portion of medicaid related ancillary services; and

(e) Social services; and

(f) Raw food; and

(g) Employee benefits associated with the direct salaries.

(7) "Director" means the director of the department of health and welfare or the director's designee.

(8) "Equity" means the new book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles.

9. "Facility" means an entity which contracts with the director to provide services to recipients in a structure owned, controlled, or otherwise operated by such entity, and which entity is responsible for operational decisions. In conjunction with the use of the term "facility"

(a) "Free-standing intermediate care" means an intermediate care facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(b) "Free-standing skilled care" means a skilled nursing facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(c) "Free-standing special care" means a facility that provides either intermediate care, or skilled care, or intermediate care for the mentally retarded, or any combination of either, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(d) "Hospital-based" means a skilled nursing or intermediate care facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is owned, managed, or operated by, or is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code.

(10) "Forced sale" is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order.

(11) "Goodwill" means the amount paid by the purchaser that exceeds the net tangible assets received. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is nonallowable, nonreimbursable expense.

(12) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect's fees, and engineering studies.

(13) "Indirect care costs" consists of the following costs either directly coded to the nursing facility or allocated to the nursing facility through the medicare step-down process

(a) Administrative and general care cost; and
(b) Activities; and
(c) Central services and supplies; and
(d) Laundry and linen; and
(e) Dietary (non-"raw food" costs); and
(f) Plant operation and maintenance (excluding utilities); and
(g) Medical records; and
(h) Employee benefits associated with the indirect salaries; and
(i) Housekeeping; and
(j) Other costs not included in direct care costs or costs exempt from cost limits.

(14) "Interest rate limitation" means that the interest rate allowed for working capital loans and for loans for major movable equipment for intermediate care facilities for the mentally retarded shall be the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (1%) at the date the loan is made. All interest expense greater than the amount derived by using the limitation above shall be nonreimbursable; provided, however, that this interest rate limitation shall not be imposed against loans or leases which were made prior to July 1, 1984. Said loans or leases shall be subject to the tests of reasonableness, relationship to patient care and necessity.

(15) "Intermediate care facility for the mentally retarded" means an habilitative facility designed and operated to meet the educational, training, habilitative and intermittent medical needs of the developmentally disabled.

(16) "Major movable equipment" means such item; as accounting machines, beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are

(a) A relatively fixed location in the building;

(b) Capable of being moved, as distinguished from building equipment;

(c) A unit cost sufficient to justify ledger control;

(d) Sufficient size and identity to make control feasible by means of identification tags; and

(e) A minimum life of approximately three (3) years.

(17)"Medicaid" means the 1965 amendments to the social security act (P.L. 89-97), as amended

(18) "Minor movable equipment" includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. The general characteristics of this equipment are

(a) In general, no fixed location and subject to use by various departments of the provider's facility;

(b) Comparatively small in size and unit cost;

(c) Subject to inventory control;

(d) Fairly large quantity in use; and

(e) Generally, a useful life of approximately three (3) years or less.

(19) "Net book value" means the historical cost of an asset, less accumulated depreciation.

(20) "Normalized per them costs" refers to direct care costs that have been adjusted based on the facility's case mix index for purposes of making the per them costs comparable among facilities. Normalized per diem costs are calculated by dividing the facility's direct care per them costs by its facility-wide case mix index, and multiplying the result by the statewide average case mix index.

(21) "Nursing facility inflation rate" means the most specific skilled nursing facility inflation rate applicable to Idaho established by data resources, inc., or its successor. If a state or regional index has not been implemented, the national index shall be used.

(22) "Patient-day" means a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3 00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care shall be deemed to exist.

(23) "Property costs" means the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal.

(24) "Raw food" means food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions.

(25) "Reasonable property insurance" means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year shall not be considered reasonable.

(26) "Recipient" means an individual determined eligible by the director for the services provided in the state plan for medicaid.

(27) "Rural hospital-based nursing facilities" are those hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States bureau of the census.

(28) "Urban hospital-based nursing facilities" are those hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States bureau of the census.

(29) "Utilities" means all expenses for heat, electricity, water and sewer.

56-102. PRINCIPLES OF PROSPECTIVE RATES AND PAYMENT. The following principles shall apply to the reimbursement of freestanding skilled care and hospital-based skilled care facilities

(1) Payments to facilities shall be through a prospective cost-based system which includes facility-specific case mix adjustments. Details of the methodology shall be set forth in rules based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state associations(s) representing hospital-based skilled care facilities. In no event shall reimbursement to any facility exceed the usual and customary charges made to private pay patients; and

(2) Each skilled care facility's case mix index shall be calculated quarterly and rates shall be adjusted based on the case mix of that facility's medicaid residents as of a certain date during the preceding quarter specified in rule; and

(3) In state fiscal year 2000, the total amount paid to skilled care facilities shall approximate the same amount in medicaid expenditures as would have been paid using the methodology in effect in state fiscal year 1999, and the percentages of medicaid funds projected to be paid to freestanding skilled care facilities and hospital-based skilled care facilities shall be the same percentages that are projected to be paid using the methodology in effect during state fiscal year 1999; and

(4) The cost limits used for the direct care and indirect care costs of rural hospital-based skilled care facilities shall be higher than the cost limits used for the direct care and indirect care costs of freestanding skilled care and urban hospital-based skilled care facilities; and

(5) In computing the direct care per diem rate neither medicaid-related ancillary services nor raw food shall be case-mix adjusted; and

(6) Property costs shall not be subject to a cost limitation or incentive. Property costs of freestanding skilled care facilities shall be reimbursed as described in section 56-108, Idaho Code, and property costs of urban and rural hospital-based skilled care facilities shall be reimbursed as described in section 56-120, Idaho Code; and

(7) Cost limits shall apply to direct care costs and indirect care costs. The cost limits shall be based on percentages above the bed-weighted median of the combined costs of both freestanding skilled care and hospital-based care facilities; and

(8) Costs exempt from cost limits are property taxes, property insurance, and costs related to new legal mandates as defined by rule; and

(9) An incentive payment shall be paid to those facilities with indirect per diem costs that are less than the established indirect care cost limit. The incentive payment is calculated by taking the difference between the cost limits and the provider's per them indirect care cost times the incentive percentage. Freestanding skilled care and hospital-based skilled care facilities shall receive the same percentage incentive payments for indirect care costs but no incentive payment for direct care costs. The percentage at which the incentive payment will be set shall be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care facilities; and

(10) A newly constructed facility shall be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation; and

(11) A facility adding new beds will have its rates for the three (3) full years following the addition of the beds subjected to an additional reimbursement limitation. This limitation will apply beginning with the first rate setting period which uses a cost report that includes the date when the beds were added. The facility's rate will be limited to the bed-weighted average of two (2) rates the facility's rate in effect immediately prior to the rate first subject to the limitation and the median rate for skilled care facilities of that type (freestanding or hospital-based) at the time the beds were added; and

(12) A facility acquired prior to the end of that facility's fiscal year will be reimbursed at the rate then in effect for that facility until the next cost report can be used for rate setting. If the department determines that the facility is operationally or financially unstable, the department may negotiate a reimbursement rate different than the rate then in effect for that facility; and

(13) If the department determines that a facility is located in an under-served area, or addresses an underserved need, the department may negotiate a reimbursement rate different than the rate then in effect for that facility; and

(14) From July 1, 1999, through June 30, 2002, the nursing facility inflation rate plus one percent (1%) per year shall be added to the costs reported in a facility's cost report for purposes of setting that facility's rate. The inflation rate to be used effective July 1, 2002, and the period of its use will be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care facilities; and

(15) To control the growth in the cost limits, the increase in the cost limits shall not exceed the skilled nursing facility inflation rate established by data resources, inc., or its successor, plus two percent (2%) per year for the period from July 1, 1999, through June 30, 2002. The maximum rate of growth in the cost limits to be used effective July 1, 2002, and the period of its use will be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care and

(16) To control declines in the cost limits, the cost limits for the period from July 1, 1999, through June 30, 2002, shall not be lower than the respective cost limits effective July 1, 1999. The minimum cost limits to be used effective July 1, 2002, and the period of its use will be based on negotiations between the department, the state associations representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care facilities; and

(17) Rates shall be rebased annually. Rate setting shall be prospective with new rates effective July I of each year, using the principles applying to skilled care facilities set forth in this chapter and the rules promulgated pursuant to this chapter. There will be no settlement between actual costs incurred during the rate year and the rate itself. Rates will be established using the most recent audited cost report trended forward to the rate year. Rates for skilled care facilities with unaudited cost reports will be interim rates established by the department until a rate is calculated based on an audited cost report. The draft audit of a cost report submitted by a facility shall be issued by the department no later than five (5) months from the date all information required for completion of the audit is filed with the department; and

(18) Changes of more than fifty cents (50) per patient day in allowable costs resulting from federal or state law or rule changes shall be treated as costs separate from the cost limitations until such time as they become part of the data used for calculating the cost limits and in cost reports used for rate setting; and

(19) If a review of the data submitted by a facility reveals errors that result in an incorrect case mix index, the department may retroactively adjust the facility's rate and pay the facility any amount by which the facility was underpaid or recoup from the facility any amount by which the facility was overpaid; and

(20) The rates established under the principles set forth in this sect ion shall be phased in using a combination of the reimbursement methodology in effect as of state fiscal year 1999 and the principles set forth in this section and in rules based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care facilities. Effective July 1, 2001, the phase-in provisions will no longer apply and the department shall pay rates solely based on the principles set forth in this section and the applicable rules.

56-108. PROPERTY REIMBURSEMENT -- FACILITIES WILL BE PAID A PROPERTY RENTAL RATE, PROPERTY TAXES AND REASONABLE PROPERTY INSURANCE. The provisions of this section shall not apply to hospital-based facilities which are subject to the provisions of section 56-120, Idaho Code, or to intermediate care facilities for the mentally retarded which are subject to the provisions of section 56-113, Idaho Code. The provisions of this section are applicable to all other facilities. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit, the director shall determine an interim rate that approximates the property rental rate. The property rental rate shall be determined as follows

(1) Except as determined pursuant to this section

$$\text{Property rental rate} = (\text{"Property base"}) \times (\text{"Change in building costs"}) \times \frac{(40 - \text{"Age of facility"})}{40}$$

where

(a) "Property base" = $9.24 for all facilities.

(b) "Change in building costs" = 1.0 from April 1, 1985, through December 31, 1985. Thereafter "Change in building costs" will be adjusted for each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year, published by the Marshall Swift Valuation Service. However, for freestanding skilled care facilities "change in building costs" = 1.145 from July 1, 1991, through December 31, 1991. Thereafter, change in building costs for freestanding skilled care facilities will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs available in September of the prior year, whichever is greater.

(c) "Age of facility" = the director shall determine the effective age, in years, of the facility by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof shall be assigned an age of more than thirty (30) years. However, beginning July 1, 1991, for freestanding skilled care facilities, "age of facility" will be a revised age which is the lesser of the age established under other provisions of this section or the age which most closely yields the rate allowable to existing facilities as of June 30, 1991, under subsection (1) of this section. This revised age shall not increase over time.

(i) If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the director shall set the effective age at thirty (30) years. Adequate documentation shall include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contracts, and original notes of indebtedness. The director shall compute an appropriate age for facilities when documentation is provided to reflect expenditures for building expansion or remodeling prior to the effective date of this section. The computation shall decrease the age of a facility by an amount consistent with the expenditure and the square footage impacted and shall be calculated as follows

1. Determine, according to indexes published by the Marshall Swift Valuation Service, the construction cost per square foot of an average class D convalescent hospital in the western region for the year in which the expansion or renovation was completed.
2. Multiply the total square footage of the building following the expansion or renovation by the cost per square foot to establish the estimated replacement cost of the building at that time.
3. The age of the building at the time of construction shall be multiplied by the quotient of total actual renovation or remodeling costs divided by replacement cost. If this number is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number. In no case will the age be less than zero.

(ii) The director shall adjust the effective age of a facility when major repairs, replacement, remodeling or renovation initiated after April 1, 1985, would result in a change in age of at least one (1) year. Such changes shall not increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the adjusted property base determined in subsections (1)(a) and (1)(b) of this section and the rental rate paid to the facility at the time of completion of such changes but before the change component has been added to said rate. The adjusted effective age of the facility will be used in future age determinations, unless modified by provisions of this chapter.

(iii) The director shall allow for future adjustments to the effective age of a facility or its rate to reimburse an appropriate amount for property expenditures resulting from new requirements imposed by state or federal agencies. The director shall, within twelve (12) months of verification of expenditure, reimburse the medicaid share of the entire cost of such new requirements as a one-time payment if the incurred cost for a facility is less than one hundred dollars ($100) per bed.

(d) At no time shall the property rental rate, established under subsection (1) of this section, be less than that allowed in subsection (1)(c)(ii), with the rate in effect December 31, 1988 being the base. However, subsequent to the application of this paragraph, before any rate increase may be paid, it must first be offset by any rate decrease that would have been realized if the provisions of this paragraph had not been in effect.

(2) A "grandfathered rate" for existing facilities will be determined by dividing the audited allowable annual property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985 by the total patient days in the period July 1, 1984 through June 30, 1985. The property rental rate will be the greater of the amount determined pursuant to subsection (1) of this section, or the grandfathered rate. The director shall adjust the grandfathered rate of a facility to compensate the owner for the cost of major repairs, replacement, expansion, remodeling and renovation initiated prior to April 1, 1985, and completed after January 1, 1985, but completed no later than December 31, 1985. For facilities receiving a grandfathered rate making major repairs, replacement, expansion, remodeling or renovation, initiated after January 1, 1986, the director shall compare the grandfathered rate of the facility to the actual depreciation, amortization, and interest for the current audit period plus the per them of the recognized cost of major repairs, replacement, expansion, remodeling or renovation, amortized over the American hospital association guideline component useful life. The greater of the two (2) numbers will be allowed as the grandfathered rate. Such changes shall not increase the allowable grandfathered rate by more than three-fourths (3/4) of the difference between the current grandfathered rate and the adjusted property base determined in subsections (1)(a) and section.

(3) The property rental rate per day of care paid to facilities with leases signed prior to March 30, 1981, will be the sum of the annualized allowed lease costs and the other annualized property costs for assets an hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983 through July 1, 1984. Effective July 1, 1989, the director shall adjust the property rental rate of a leased skilled facility under this paragraph to compensate for the cost of major repairs, replacement, expansion, remodeling and renovation initiated after January 1, 1985, by adding the per them of the recognized cost of such expenditures amortized over the American hospital association guideline component useful life. Such addition shall not increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the current property rental rate and the adjusted property base as determined in paragraphs (a) and (b) of subsection (1) of this section. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement shall be at a rate per day of care which reflects the increase in the lease rate. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement shall be at a rate per day of care which reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters costs. After the effective date of this subsection ' if such a lease is terminated or if the lease allows the lessee the option to terminate other than by purchase of the facility, the property rental rate shall become the amount determined by the formula in subsection (1) of this section as of the date on which the lease is or could be terminated.

(4) (a) In the event of a sale, the buyer shall receive the property rental rate as provided in subsection (1) of this section, except under the conditions of paragraph (b) of this subsection or except in the event of the first sale for a freestanding skilled care facility receiving a grandfathered rate after June 30, 1991, whereupon the new owner shall receive the same rate that the seller would have received at any given point in time.

(b) In the event of a forced sale of a facility where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, whichever is higher, but not exceeding the rate that would be due the seller.

56-114. FREESTANDING SPECIAL CARE FACILITIES. For a freestanding special care facility which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment for such facility as specified in rule.

56-117. PAYMENT OF SPECIAL RATES. The director shall have authority to pay facilities at special rates for care given to patients have long-term care needs not adequately reflected in the rates calculated pursuant to the principles set forth in section 56-102, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of section 56-102, Idaho Code, will be excluded from the computation of payments or rates under other provisions of this chapter. Until the facility applies for a special rate, patients with such needs will be included in the computation of the facility's rates following the principles described in section 56-102, Idaho Code.

56-120. PROPERTY REIMBURSEMENT FOR HOSPITAL-BASED SKILLED NURSING FACILITIES. In addition to the basic payment per patient-day of care, each hospital-based skilled care facility shall be paid on a prospective basis its actual property and utility costs per patient-day, to be determined by dividing its total projected property and utility costs, as calculated from the cost report selected for rate setting, by the total number of patient-days from the same cost reporting period.

56-131. MULTIPLE-USE PLANS. The director shall promulgate such rules, as the director deems advisable to enable and encourage facilities to adopt plans for offering additional services or programs within their institutions which will promote appropriate levels of care for recipients residing in their service areas and, as a result, achieve cost savings for the medicaid program. In developing such rules, the director shall consult with representatives of freestanding skilled care, freestanding intermediate care, freestanding special care, and hospital-based facilities.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

4.19E The Department of Health and Welfare PH-1-78 Physician Invoice Claim, the DHW 01-78 Title XIX Pharmacy Claim, the DHE-AD 78 Adjustment Request Claim, the DHW-OP-78 Hospital Outpatient Claim, the DHW 1P1-78 Hospital Inpatient Claim, and DHW 0137 Attending Dentist's Statement claim will be utilized by the Department of Health and Welfare. For definitional purposes the Department defines a bill for each of the above as all services provided one recipient submitted on a single claim form.

For drug claims the number of line item entries cannot exceed three (3) line item entries and on physician invoice claims, the number of line item entries cannot exceed fourteen (14) line item entries.

The DHW NH 1-78 Nursing Home Statement will be utilized by the Department of Health and Welfare. For definitional purposes the Department of Health and Welfare defines a nursing home bill as a line item of services not to exceed ten (10) individual recipient bills on each claim submitted.

79-16 eff 10/1/79